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Doctorate in Professional Studies

**The Experience of Post-qualifying Healthcare Students of
University-based Continuing Professional Development**

DPS 5260

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August 2014

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Abstract

This project focussed on the experiences of healthcare continuing professional development students in a higher education institution. A scoping exercise indicated that although there was a focus on the student experience, this did not necessarily extend to healthcare CPD students.

The project comprised two research questions and subsequent lines of enquiry: What factors do key stakeholders believe need to be taken into account in healthcare CPD curriculum planning, development and delivery?, and What is the nature of the student experience for healthcare CPD students studying at Middlesex University?

The stakeholder–curriculum line of enquiry used an action research-based approach. Two cycles of activity took place, based on feedback from key stakeholder groups. Thematic analysis of data from the stakeholder groups was used to produce a draft Curriculum Principles Document that was piloted in practice. Interview data provided by the curriculum developer were used to produce a final version, along with a Staff Guide.

Data for the student experience line of enquiry was collected from questionnaires and a focus group. Analysis of data from the questionnaire enabled the construction of a healthcare CPD student profile. Focus group analysis generated seven themes, two of which were new perspectives: perception of self as a University student, and the lone study experience.

It is argued that there is a conceptual dissonance between the professional body requirement to engage in lifelong learning and CPD activities, and the reality of that engagement in a higher education context. A healthcare CPD student transition model is proposed.

Findings from the student-stakeholder group and the focus group were used to produce recommendations for education practice based on a four-point model for enhancing the healthcare CPD student experience: 1) preparation for CPD study; 2) teaching, learning and assessment strategies for CPD; 3) multi-stakeholder, solution-focussed University services; and 4) a healthcare CPD consultancy and advice service. Recommendations for future research based on the concept of engagement and transition for other professional groups engaged in CPD are suggested.

The implementation of this healthcare CPD student experience project has provided new insights into the healthcare CPD student experience leading to the development of a model aimed at enhancing that experience. As a result of dissemination of findings, CPD students have a higher profile within the University.

Abbreviations

APAC	Academic Provision Approval Committee	HEFCE	Higher Education Funding Council for England
APC	Academic Planning Committee	HEI	higher education institution
APL	Assessment of Prior Learning	LETB	Local Education and Training Board
APPG	Academic Programme Planning Group	LLL	lifelong learning
AR	action research	LoE	lines of enquiry
BCI	Business and Community Initiatives	LTA	learning, teaching and assessment
BoS	Board of Studies	LUN	Learning Unit Narrative
CCSS	Central Computer Services	MISIS	Middlesex Integrated Student Information System
CDS	Curriculum Development Strategy	MUSU	Middlesex University Student Union
CDT	Curriculum Development Team	NCBC	non-credited provision, known as non-credit-bearing courses
CINAHL	Cumulative Index to Nursing and Allied Health Literature	NHSL	NHS London
COI	community of inquiry	NMC	Nursing and Midwifery Council
CoP	community of practice	PA	practice assessors
CPD	continuing professional development	PDP	Personal Development Profile
CPE	continuing professional education	PGCE	Postgraduate Certificate in Education
CPI	contract performance indicators	PQSG	Post-qualifying Steering Group
CPPD	Continuing Personal and Professional Development	PT	practice teacher
CPrD	Curriculum Principles Document	RCN	Royal College of Nursing
DipHE	Diploma in Higher Education	SEG	Student Experience Group
DoP	Director of Programmes	WBL	work-based learning
DoSE	Director of Student Experience	PQ	post-qualifying
DVC	Deputy Vice Chancellor	PSRB	Professional Statutory Regulatory Body
ERC	Education Research Complete	RAG	red, amber green
FHEQ	Further and Higher Educational Qualification	SHA	Strategic Health Authority
HCPC	Health and Care Professions Council	V&A	Validations and Approvals (committee)
HE	higher education	V&R	validations and reviews
HEE	Health Education England	VLE	Virtual Learning Environment

Chapter 1 Introduction

1.0 Background

This project is submitted as the final part of a Doctorate in Professional Studies (Healthcare Curriculum Leadership and Development in Higher Education) and comprises 54,934 words. My doctoral studies started with a review of learning in which I explored learning that took place prior to the start of my doctorate, the factors influencing that learning and the impact that it had on my professional experience at that time. This theme is revisited, as I have linked the review of learning and learning from professional practice to learning from engagement and completion of this project.

Learning from professional practice in healthcare curriculum leadership formed the core of the two claims made for recognition and accreditation of prior learning. The first demonstrated expertise and leadership in the context of curriculum development and the second in research capability in healthcare education. The project took longer to complete than I anticipated and desired, partly because of a significant change in my work role in 2007 from a focus on pre-registration child health and post-registration primary healthcare to an operational leadership role focussing on post-qualifying nursing and midwifery continuing professional development (CPD). The change in a key aspect of my role led to a change in the focus of my final project.

The aim of the final project was to explore the experiences of healthcare CPD students in higher education (HE) and to use the findings to raise the profile of healthcare CPD students within the University and to impact positively on organisational processes. A key aspect of the CPD student experience is the nature and quality of specific education provision offered by the higher education institution (HEI), and this study aimed also to explore students' and other key stakeholders' views about the factors that they felt should be taken into account in the provision of healthcare CPD.

There is no single definition of CPD in the context of the health and care professions, however across the disciplines there are common features based on the maintenance and development of professional competence by keeping knowledge, skills and behaviours up to date.

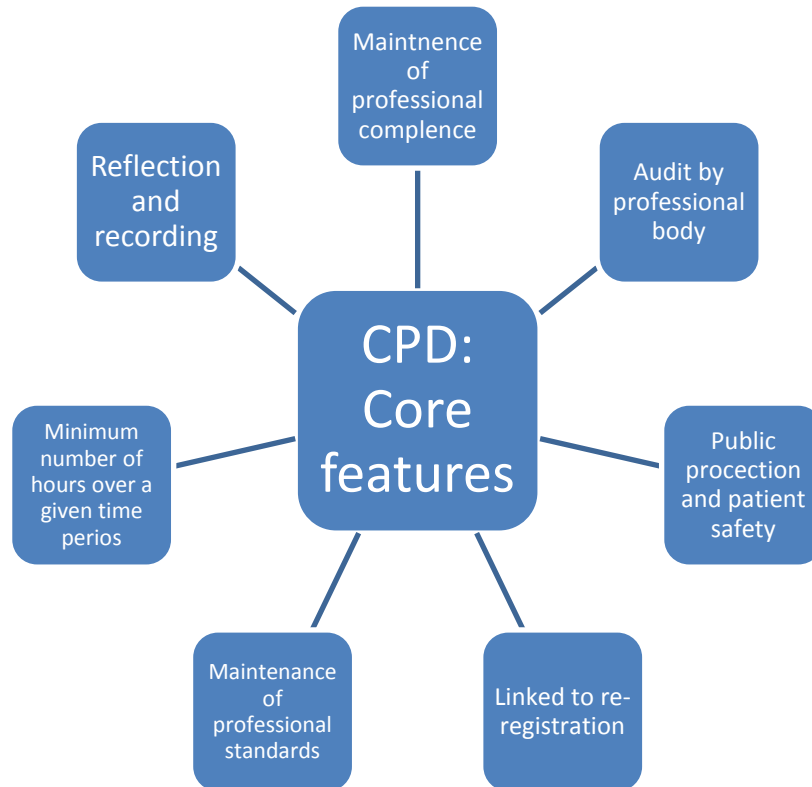


Figure 1: Continuing professional development: common features across healthcare disciplines

Most healthcare professional bodies suggest that CPD may be formal, or self-directed and informal; some require practitioners to demonstrate that they have engaged in CPD activities that enable them to continue to meet specific professional standards. Generally, the practitioner is required to notify the professional body about their CPD activities. This varies from on-going notification of each CPD activity (General Dental Council) through to a notification to practice that confirms that the practitioner has engaged in the required amount of CPD activity (Nursing and Midwifery Council). For nursing and midwifery, the overarching purpose of CPD is public protection and patient safety.

In this project CPD is seen as key to the maintenance and development of professional standards and, in addition, in the context of higher education. This last is the focus of this project; through accredited programmes of study at undergraduate and postgraduate level, CPD offers the healthcare practitioner an opportunity to develop personal and professional capital and, in doing so, to enhance career prospects and personal position in the community and in the workplace. CPD in the higher education setting facilitates the development of critical thinking, clinical decision making and higher order cognitive skills. The acquisition of these skills contributes to and enhances clinical and professional practice and service development, as well as enabling nurses to make informed and critical contributions as an equal member of the multi-disciplinary healthcare team.

A naturalistic, qualitative research approach was adopted within which were two lines of enquiry. The study had a co-operative focus and used in-method triangulation. Final products were: a Curriculum Development Principles Document; a Staff Guide, a CPD resource portfolio, an interim paper to the Director of the Student Experience, a healthcare CPD student transition model and a four-point healthcare CPD student experience enhancement model.

This chapter focusses on the period between 2007 and 2010 and the first three years of my role as Director of Programmes with operational responsibility for healthcare CPD—the period of problem identification from which the research questions emerged. It then sets the ‘problem’ in a wider historical and contemporary context, and next provides an outline of the structure of each of the chapters in the report.

1.1 The emerging picture and problem identification

As part of my role as Director of Programmes (DoP) and the operational lead for healthcare CPD, I carried out a scoping exercise and, from its results, it was possible to start to identify what the key ‘problems’ were in relation to healthcare CPD provision. Two areas of concern were identified. The first was that University and School processes and procedures did not reflect the CPD student experience despite the University’s explicitly stated commitment to and focus on the student experience and the appointment of a Director for Student Experience. My reflections and conclusion as a result of this initial activity were that the CPD student experience was—to borrow a phrase from Meerabeau (2005: 125)—invisible and inaudible, and that the needs of the dominant group of students were prioritised over those of the minority.

The second area of concern was the subject-based ‘silo’ approach to curriculum development, despite the existence of a healthcare CPD strategy. A possible reason for this might have been that the strategy was developed in a top-down manner by staff who were not directly involved in curriculum planning, development and delivery. In addition, although it was likely that the strategy had ‘high level’ relevance, a key challenge to its adoption in curriculum planning was that it failed to consult key healthcare CPD stakeholders directly and use their response to inform strategy development. As a result there was little or no buy-in to a joined up, integrated healthcare CPD curriculum philosophy.

Following the identification of the main issues, I was able to articulate what seemed to me personally and professionally to be the main areas of concern. These were that the University, as an organisation, despite an explicit commitment to enhancing the student

experience, was not necessarily meeting the needs of a specific group of students. In its commitment to improving the experience of the core or dominant group there was an assumption that any actions or strategies would also meet the needs of the minority. What was interesting was that colleagues who held similar positions as me but with responsibility for pre-registration nursing had similar concerns about University-wide policy and strategy development, which again did not reflect the needs or experiences of that particular group. However, what was different about this group was that there seemed to be a larger body of more senior staff who were also voicing their concerns. One reason for this might be the differences in perception of the 'value' of each group in terms of the level of income, with healthcare CPD contributing only approximately one tenth of that of pre-registration nursing education. At the time there appeared to be a prevailing view that 'nursing' as a collective entity in HE was 'different'—which was probably true. Yet, in my view, whilst having some similarities with pre-registration healthcare in terms of student need and experience, healthcare CPD students may also have unique needs and experiences. I felt very strongly at the time that I was perceived as the DoP who 'bangs on about CPD'. At times I felt like a stuck record and that I was hitting my head against a brick wall.

Generally speaking policy, process, procedure and practice focussed on the full-time, Higher Education Funding Council for England (HEFCE) funded programmes or on NHS funded healthcare students on full-time programmes. Even the notion of 'programme' was problematic in this regard for healthcare CPD, as much of the provision has a modular focus. A review of some of the core activities and committees in the HEI provides some insight:

Table 1: Main University committees and processes and the relationship to healthcare CPD

University Process or Committee	Relationship to Healthcare CPD
National Student Survey (NSS)	<ul style="list-style-type: none"> • 3-year full-time HEFCE focus • Nursing and Midwifery representation, pre-registration only. Healthcare CPD students not required to complete.
University Learning Framework	<ul style="list-style-type: none"> • Programme rather than module focus. • 30 credit modules delivered over 24 weeks. • Feedback from key stakeholders involved in healthcare CPD provision suggested that 24 weeks was too long in the context of staff release. 12 week modules preferred. The approach ignores the way in which most healthcare CPD students access education provision, i.e. on a part-time module-by-module basis (as opposed to accessing longer programmes in the first instance).
Progression Boards	Programme focussed, but still a need to monitor the academic progress of healthcare CPD students and acknowledge achievement, where appropriate.
Boards of Study	Programme focussed. Healthcare CPD student

Induction	<p>representation is poor due to the mainly modular and part-time nature of healthcare CPD provision, coupled with difficulties in obtaining release time from practice for attendance at anything other than actual class-based teaching.</p> <p>Initially not on the campus where most healthcare CPD was delivered. This changed after the closure of the Enfield Campus and the relocation of some programmes (as opposed to modules) to Archway. Aspects of the induction experience have been continuously highlighted in feedback by students to academic staff and through BoS, specifically problems with enrolment and consequently ability to access learning resources and the virtual learning environment. This exacerbated by the modular, part-time nature of healthcare CPD.</p>
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It seemed to me that it was imperative to discover more about the healthcare CPD student experience generally, and in HE specifically. In my view, it is only when users of a service are consulted about their needs, requirements and experiences that services can be developed to reflect these.

Key questions at this stage were: how can I find out more about the healthcare CPD student experience? How can I raise the profile of healthcare CPD students in HE so that the organisation is aware of their needs and priorities? How can I ensure that their voice is heard? What has already been written about this? I envisaged that the information collected as result of asking these questions as part of a research project could be used to inform healthcare CPD curriculum strategy, and to inform policy and procedure development and marketing strategy.

It was also important to acknowledge that, in terms of curriculum development and delivery, healthcare CPD students were not the only stakeholders. Additional questions arising from the scoping work were: How can I increase my understanding of what is important to key stakeholders in terms of healthcare curriculum provision? How can I use this to inform the development of a healthcare CPD strategy?

My work as a DoP, as a programme leader and a module teacher between 2007 and 2010 provided me with some limited insight into the healthcare CPD student experience and, as a result, I was inclined to make certain assumptions. These included, for example, that the healthcare CPD student experience was different, possibly worse than that of full-time students. I had to acknowledge, however, that although this assumption was made on the basis of a significant amount of experience healthcare CPD teaching and leadership, it was not based on information gathered direct from students themselves apart from the usual module and programme evaluations. It was entirely possible that the

healthcare CPD student experience was better than that of full-time students, or that the full-time student experience was also problematic in similar or different ways. This suggested to me that perhaps I needed to find out about the full-time student experience, too. I struggled and reflected with this for some whilst then decided at this stage I needed to settle on finding out what was important to the CPD student about the nature of their experience and perceptions of performance of the University. My job and work-based experience focussed on healthcare CPD, therefore I decided that this should form the core of my inquiry. The final research questions to be answered were therefore:

- What is the nature of the student experience for healthcare CPD students studying at Middlesex University?
- What factors do key healthcare CPD stakeholders believe should be taken in account in the development and planning of education provision for PQ healthcare CPD students?

These two research questions were managed as separate lines of enquiry (LoE) within an overarching study.

1.2 Key developments in nursing education: Setting healthcare CPD in an historical context

The development of nursing education during the 1990s can be characterised in two ways; a move into HE and a 'marketisation' of healthcare CPD. The gradual move into HE was accompanied by a change in pre-registration nurse education programmes, which were typically offered at Diploma in Higher Education (DipHE) level with students gaining academic credit in addition to a professional award. CPD provision followed suit in terms of academic credit and in some cases it was possible also to gain a professional award. From a personal perspective, 1995 saw the incorporation of North London College of Health Studies where I was employed at Middlesex University. I was part of a team engaged in developing new CPD women's health-related modules that were validated at Levels 2 and 3 (now Further and Higher Educational Qualification (FHEQ) Levels 5 and 6), enabling nurses with certificate level qualifications to use the credits gained from CPD studies to 'top up' to a Dip HE award, in line with newly qualified nurses, and to gain a professional award. From 2000 onwards nursing education was characterised by a gradual move from DipHE to degree level for all pre-registration programmes (NMC, 2010) and a similar shift in focus for healthcare CPD student to using credits gained from the completion of CPD modules to gain a degree. My role then, as now, included being programme leader for a post-registration BSc (Hons) Nursing Studies—typically referred to by students as a 'top-up' degree.

Meerabeau (2005: 127) suggests that the movement of nursing into HE may be viewed in the context of an occupational hierarchy and argues that nurses' experiences in higher education replicates their experience in the healthcare setting where, as a result of their position in the healthcare hierarchy, they had (and still have?) difficulty in 'finding a voice' (Meerabeau, 2005: 139). In the context of HE, not only was nursing inaudible *vis à vis* medical education but within HE generally, compared to older, more established disciplines. Royal (2012) takes a similar view, arguing that the position of student nurses in HE did not bring them into line with other undergraduate students. The concept of cultural capital is valuable here to shed light on and explain the position of nursing. Cultural capital—a theory first espoused by Bourdieu in the 1960s—is described by Royal (2012: 20) as referring to 'the norms and values individuals carry subconsciously... that shape understanding and behaviour'. Both Meerabeau and Royal argue that nurses are viewed as having low cultural capital in comparison to doctors and other undergraduate students (Meerabeau, 2006; Royal, 2012). It is worth noting that Meerabeau applies the same thinking to the experience of nurse academics as well as nursing students in HE (Meerabeau, 2006).

In my work in healthcare CPD, and as result of the scoping work that I carried out when I was first in post, I became increasingly passionate (some might say obsessed) by the position of the healthcare CPD students within the University. I was irritated by their apparent invisibility and tired of repeating myself in various forums, asking whether healthcare CPD had been factored into the issue being debated or announcing that a proposed process 'won't work for CPD students'. At times I was inclined to associate 'invisibility' with lack of concern about the experience of this particular (minority) group. In preparation for this project I spent time reflecting on my personal value system and how this influenced my interpretation of events. My reflections were rooted in my early professional experience as a nurse. These are discussed as key issues in the first piece of work that I completed for doctoral study—my review of learning. During my time as a student and then as a qualified nurse I swiftly developed an awareness of the occupational hierarchy within the healthcare workforce. The lived experience of being 'only a nurse' *vis à vis* medical staff, even in a relatively senior post as a ward manager, definitely impacted on my thinking and challenged my personal value system, which was and still is based on fairness and equity. I was inclined to believe that my obsession, passion and determination to make the voice of the health CPD student audible was rooted in those early workplace experiences and interactions with other members of the multi-disciplinary team in the healthcare practice setting. It was also possible or even

probable that my experience of transferring into HE and my new role as a healthcare academic influenced my thinking.

2007 was a landmark year for nursing. In November two consultation documents related to nursing and nurse education were published. The Nursing and Midwifery Council (NMC) publication related to the future of nurse education and culminated in the publication of standards for pre-registration nurse education that, from 2011, was to be offered only at degree level or above. At the same time as this consultation was taking place, the Department of Health published a consultation document that proposed a new careers framework for qualified nurses. The response report was published the following July. The outcome was a document setting out the future direction for nursing and midwifery in which there was a further commitment to modernising nursing careers and educational pathways (DoH, 2008: 17).

The second way in which nursing education was characterised during the 1990s was what might be called the 'marketisation'. This impacted on both healthcare provision and healthcare education, representing the separation of the purchaser and the provider of services. In terms of healthcare education, this resulted in increased competition between HEIs in the context of the annual round of commissioning healthcare CPD provision in a relatively open market. Commissioning choices could be influenced by cost, location, historical partnership preferences, the relationship between the commissioner and the HEI, the types of provision and the nature of the CPD experience for Trust staff undertaking CPD studies. The focus on marketisation continued throughout the 2000s.

May 2010 saw the election of a Coalition government with a clear focus on deficit reduction, which affected all public services including health and HE. The White Paper *Equity and Excellence: Liberating the NHS* was published in July 2010 and the Health and Social Care Bill was introduced in Parliament in January 2011, with a second reading in February. The well-publicised objections to key aspects of the Bill, including the focus on competition and choice that was seen as a threat to quality and the composition of GP consortia, did not stop it from progressing to the Committee stage, yet in response to the disquiet the Coalition established the NHS Futures Forum that made recommendations based on an extensive 'listening exercise'. Four themes emerged, one of which focussed on the importance of education and training and the need for 'a renewed and strengthened focus on continuing education and development' (NHS Future Forum, 2011). The Bill gained Royal Assent in March 2012. The significant change in health policy that impacted on healthcare CPD was the disbanding of the Strategic Health Authorities responsible for funding healthcare CPD. This role became the responsibility of Health

Education England (HEE) and the LETBs. The LETBs' focus in London emphasised quality educational outcomes, value for money, clinical excellence efficiency and collaborative curriculum planning in the context of multi-professional education (NCEL LETB, 2012).

1.3 Nursing and nurse education in crisis

The late 2000s was a particularly turbulent period for nursing, given the reports of avoidable deaths at the Mid-Staffordshire NHS Trust for which, in the media at least, nurses were blamed. In March 2010 the report by the Prime Minister's Commission on the Future of Nursing and Midwifery in England was published, reflecting on-going concerns about 'widely publicised variations in the standards of nursing and midwifery care' (Prime Ministers Commission on the Future of Nursing and Midwifery in England, 2010: 2). The first Mid-Staffordshire NHS Trust Inquiry started in November 2010 and published its report in December 2011.

The public discourse around patient safety and standards of nursing care continued, resulting in the setting up of the Willis Commission by the Royal College of Nursing (RCN) in April 2012. Willis reported in November 2012. An important finding was that there were no shortcomings in pre-registration nurse education that could directly account for poor practice. In addition, and significant for this study, one of the five key themes in the report recognised the importance of employer-funded, promoted and supported CPD. Between 2012 and 2013 *Compassion in Practice* was published in December 2012, the Francis Report of the second enquiry into the Mid-Staffordshire NHS Trust in February 2013, the Berwick Review into Patient Safety in August 2013 and the Keogh Review of Urgent and Emergency Care in August 2013. The level of scrutiny to which nursing was subject at this time was unprecedented and uncomfortable. It required HEIs to demonstrate to commissioners of healthcare CPD more than ever that HEIs were aware of the prevailing context of healthcare.

Universities and health/nursing academics hold the key to creating the conditions that can help to challenge the low cultural capital of nursing. I would argue that conditions may be generated at two levels: firstly through the development of effective relationships with healthcare practitioners and working in collaborative partnership at unit, department and organisational levels to increase social capital in the workplace; and secondly by using the purposes of higher education to raise their own social capital in higher education through the cultivation of an internal and external nursing research profile.

Royal (2012) points out that, despite the fact that nurses constitute the largest group of healthcare workers in employment, as a group nurses lack cohesion and solidarity and, as such, have not exploited the potential afforded by groups to increase their social capital. She argues that through building social networks in the workplace and through professional associations based on community and reciprocity, nurses have the potential to influence policy and practice at national levels. The development of effective social networks engaged in professional reflection and debate about the nature and purpose of nursing provides the space and opportunity for nurses to define nursing in their own terms and through their own lens and, in doing so, to construct their own identity. Through these activities the public perception of nurses and nursing can be challenged by raising public awareness of the broad spectrum of skill and knowledge required for effective nursing practice in many and varied roles. The development of strong and effective social networks that gives nurses a sense of occupational self also puts them in a better position to take their place in and contribute to wider healthcare social networks. Read (2014) argues that positive leadership practice is an essential requirement for the development of social capital. Effective leaders are vital in creating a culture built on 'trust, solidarity and resilience', which in turn strengthens social capital at unit and organisational levels (Read, 2014: 1003). Nursing academics—through clinical supervision, mentoring, consultancy and partnership working with clinical leaders can, in this way, play a part in enhancing nurses' social capital in the workplace.

In Chapter 1 I argue that engaging in CPD delivered by nursing academics in a higher education context enables nurses to develop personal and social capital that can then be used in the workplace. Nursing academics can also play a key part in challenging and raising nurses' cultural capital by engaging in collaborative research with practitioners to raise awareness of the contribution that nursing makes to health and wellbeing, and that raises awareness and understanding of the unique nature of nursing. Engagement in research is crucial to increasing nursing academics' cultural capital in the context of higher education. Internal and external recognition of the quality of that research is an essential requirement. Sharts-Hopko (2013) suggests that there are two dimensions to engagement with research. She argues that all nurses educated to graduate level need to know how to contribute to the development of data sets, to organise and manipulate data, and to analyse and evaluate data. For some nurses there is an additional requirement. They need to 'be able to critique the state of the science within and beyond the discipline of nursing about a given topic....' (Sharts-Hopko, 2013:107).

However, nursing is a relatively recent arrival in HE compared to medicine and other older, more established disciplines and, as such, has had limited time and opportunity to develop a high profile research standing, and to gain acceptance by the wider University and healthcare professional community. Part of the reason is the tensions and challenges for nursing academics in terms of balancing research, teaching and practice. What is needed is for nursing academics to work with University structures and processes to recognise the plurality of professional knowledge and to create conditions that enable them to engage in high quality research activity. This is as much a staff resourcing issue as a research training and capacity-building issue. Nurse academics are to be supported from within to balance teaching, practice and research activity—including collaborative research with healthcare colleagues, as described above. Collaborative research relationships can be facilitated through the development of a staffing strategy based on HE–Trust partnerships, joint appointments, honorary contracts (HE and Trust) and a locally agreed clinical–academic pathway. What needs also to be recognised is the *practice* of nurse education and the need to raise the cultural capital of nursing academics in HE whose professional and academic expertise is located in education.

In terms of raising cultural capital it is important to keep in mind that building research capacity and capability, and increasing research output take place in a political context. It is important that healthcare academics learn the rules and understand ‘how the game is played’ and what is needed to compete on equal terms with other professional and academic networks. It is also fair to say that academics based in older, more established disciplines in pre-1992 research intensive universities have been ‘playing the game’ for a much longer period and so probably understand better the way in which the research world operates. Healthcare academics need to learn how to engage with that world effectively and successfully.

Working in partnership with practitioner colleagues with the aim of improving nurses’ social capital; participating in collaborative research with practitioners and nursing academics in other HEs; balancing research, teaching and practice in HE; publishing in high impact journals; presenting at high level conferences and engaging with policy makers, in their different ways, may result in raising the cultural capital of nursing academics and nursing students in HE, and of nursing as a discipline. Read (2014) argues that increasing nurses’ social capital at work results in benefits to patients, to nurses in the workplace and to the organisation. By enhancing the social/cultural capital of nursing academics in HE, it should therefore be possible to win parallel benefits: to students, to nursing academic staff and to the University.

Earlier in this chapter I discussed how I arrived at project research questions. This forms the starting point for the remaining chapter in this project report.

1.4 The structure and format of the project report

The focus of this study is healthcare CPD students' experience in HE, and their and other key stakeholders' perceptions of factors to be taken into account in healthcare CPD planning, development and delivery. Chapter 2 describes the results of a review of the literature on healthcare CPD, focussing on the nature of healthcare CPD, the healthcare CPD student experience and the role of stakeholders in healthcare curriculum development and in HE. The literature review spanned 2007 to 2013, on the basis that research reports appearing in journals during this period will have taken up to a year from acceptance to publication. It was reasonable, therefore, to suggest that the earliest research that featured in the review was being undertaken in 2005 and accepted for publication one to two years later. The review ends in 2013. Arguably, therefore, the literature review represents the political, professional, health and educational milieu of the years 2005/06 to 2011/12.

Five themes were identified: the concept of CPD; healthcare CPD students' experiences—perception, motivation and participation; the impact of healthcare CPD on practice; teaching and learning strategies in healthcare CPD; and finally the nature of the stakeholders in the HE setting. There was some reference to CPD in the context of HE in the literature, but little written on the healthcare CPD student experience of studying in HEI, suggesting that new insights might be gained as a result of this project, adding to the existing body of knowledge.

Chapter 3 focusses on the findings from the research literature and on the decision-making processes involved in matching the research questions to the appropriate research approach. Starting with a review of each of the three main research paradigms, the research approaches of each are explored. The research questions were treated as separate but potentially overlapping lines of enquiry: the student experience line of enquiry and the stakeholder–curriculum line of enquiry. The rationale for the final choice of research approach for each line of enquiry is discussed. This chapter also explores the issues around reflexivity and the nature of the relationship between the researcher and the key stakeholders. The complex issues around positionality and the insider–researcher drawing on the work of Herr and Anderson (2005) are discussed in the context of the stakeholder–curriculum and the student experience lines of enquiry. Discussed here is the issue of whether the studies represent research 'on', 'by' or 'with'

stakeholders representing different perspectives on the nature of collaboration.

Approaches to data collection and analysis within action research (AR) and interpretative research are discussed. The literature around mixed methods and triangulation is explored with a particular emphasis on the student experience line of enquiry.

The ethical dimensions of the study are also discussed in this chapter. The fair opportunity rule is considered here in terms of 'undeserved disadvantages' and 'denied benefits' applied to the healthcare CPD student context. Ethical dimensions within AR and interpretative research are also reviewed. Issues of rigour in AR are discussed and uncertainties around the research approaches are considered in the light of the need to use the most appropriate and relevant quality criteria for the study, and are finally resolved.

Project activity and project findings for the each line of enquiry are integrated in this report and as such form the basis of Chapters 4 and 5. Chapter 4 focusses on the stakeholder–curriculum line of enquiry and Chapter 5 student experience. In these chapters the intended and actual project activity is discussed and the reasons for the final approach taken are explained, with reference to the insider–researcher role and the need to utilise work forums for research purposes. This was especially the case for the stakeholder–curriculum aspect of the project. In this line of enquiry two cycles of activity are described, based on two 'problems': the absence of a Curriculum Development Principles Document derived from stakeholder consultation and the need to pilot the Principles Document. Chapter 4 charts the progression of the research from thematic analysis of data from the stakeholder consultation through to the production and testing of a pilot Curriculum Principles Document. Findings from the pilot are discussed and, based on this, a University–stakeholder value re-enforcement model is proposed. The project activity and findings from the student experience line of enquiry are discussed in Chapter 5, with specific reference to new insights into the healthcare CPD experience. A model based on the concept of transition is proposed in the light of the findings from this aspect of the project and a four-point healthcare CPD student experience enhancement model is offered, also derived from the findings.

In Chapter 6 the four-point model is discussed in more detail and consideration is given to whether the project as a whole has shed light on the CPD student experience and raised the healthcare CPD student profile. I argue that it has, although not necessarily in the ways anticipated, and that the changes that can be seen within the University in relation to healthcare CPD, representing organisational awareness and slow process change rather than wholesale organisational transformation. Personal and professional learning and

development were also significant outcomes from this project and these are discussed in the final chapter.

The project resulted in five products. Two of these, the Curriculum Principles Document and the Staff Guide, can be found in the third: the CPD resource portfolio. This was created in PebblePad as a webfolio and can be accessed by accessing the following link: <https://www.pebblepad.co.uk/middlesex/viewasset.aspx?oid=409470&type=webfolio>

The fourth product is a healthcare CPD transition model and the fifth a four-point model for enhancing the student experience.

Chapter 2 Literature Review: Continuing professional development for nurses and higher education

2.0 Introduction

The chapter focusses on the stakeholder and CPD literature, showing how the research questions and the project were influenced and informed by the review. It starts with a short review of the search process and the rationale for databases used, search parameters and the health and policy contexts forming the background to the literature. The two research questions of the project formed the basis of two core searches that I have termed the student experience search and the stakeholder search. Although these were carried out as separate searches, following the review an integrated approach was taken in the analysis. Five themes were identified: the concept of CPD; healthcare CPD students' experiences—perception, motivation and participation; the impact of healthcare CPD on practice; teaching and learning strategies in healthcare CPD; and finally the nature of the stakeholders in the HE setting. The chapter ends with a discussion on the impact of the literature on the study design.

2.1 The search process

The following databases were used:

- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Medline
- Education Research Complete (ERC).

The CINAHL and Medline databases have a wide degree of overlap, and cover both nursing and allied health professionals' literature. However, as CINAHL is an American resource and Medline a more generic source, it was decided to use both (Aveyard, 2010: 76). The inclusion of the ERC database as a source of literature was imperative. This database has a focus on research on education and professional development published in education journals on a range of subjects. Given the nature and focus of the project on the student experience and curriculum development, it seemed crucial in conjunction with those with a health focus to use a database with this education focus.

In making my choice of literature I identified the following broad areas to form the starting point for my search strategy. These were:

- Continuing professional development
- Higher education
- Healthcare practitioners
- Stakeholder engagement.

For each of these broad areas I needed to refine and focus the search, based on the development of appropriate inclusion/exclusion criteria broad enough to capture the literature on the healthcare CPD student experience, but not so wide as to include healthcare students' study experiences not directly relevant to the proposed study and the research questions.

The CPD and the higher education searches were based on the need to determine what types of education experiences and settings would be relevant and thus included in the study. The focus therefore was University-based education excluding any in-house Trust provision offered on Trust premises. Further decisions about what types of CPD would be included in the study would be determined from a detailed reading of the literature.

The composition of the CPD student body was an important criterion guiding the search. From an initial decision to include a broad range of healthcare practitioners, I subsequently decided to exclude doctors, dentists and veterinarians. The rationale was that CPD for this group largely takes place outside of the university/higher education setting. I opted to include nurses, midwives and allied health professionals as for these professionals a significant amount of CPD takes place in HE. Healthcare students on pre-registration programmes were excluded on the basis that their experience of university was different from those on CPD provision; I reasoned that it was more likely to reflect that of full-time three-year than of CPD students.

In relation to the stakeholder–curriculum line of enquiry, the search was determined by the need to gain insight into the extent of stakeholder involvement, firstly in higher education in general and specifically in healthcare curriculum planning. The findings from the literature were to inform decisions on which stakeholders to include in my study.

This was a particularly testing experience that required a systematic approach, ideally in an uninterrupted block of time in which to complete the search. In reality the search took much longer than I anticipated and was characterised by a fragmented rather than a seamless approach. When the same references appeared using different databases, however, I was confident that I had retrieved most that had been published in peer-reviewed journals.

The use of limits was important to ensure that literature retrieved was relevant and specific in terms of age, subject and quality. The date range was 2007 to 2013. This was an important decision made in the light of the key events occurring then in nurse education, in the Health Service and in terms of health and education policy. The literature review commences in 2007 and ends in 2013. Arguably, therefore, it represents the political, professional, health and educational milieu of the years 2005/06 to 2011/12. This period was a tumultuous time for nursing and midwifery, with changes to the education setting in the mid-1990s followed by changes to the level of pre-registration nurse and midwifery education training in the 2000s. The change in direction of health and education policy coupled with serious concerns about patient safety and the quality of nursing care forms the backdrop to this review.

The focus of this project and its two lines of enquiry is stakeholder attitudes, beliefs, experiences and perceptions in the context of CPD. According to Aveyard (2010), including qualitative and naturalistic studies in the review is likely to yield data that contribute to the understanding of the phenomenon. The research questions in this study focus on the former: qualitative.

The table below shows the types of literature retrieved for each research question, having been identified from the abstracts as most relevant to the study and worth incorporating in the review. Studies carried out in Eire, Australia, New Zealand, USA, Canada and South Africa as well as those in the UK were included.

Table 2: Number and types of literature retrieved for the literature review

	Qualitative	Quantitative	Mixed	Scholarly writings	Other
Student experience literature	17	8	1	7	3*
Stakeholder– curriculum literature	2	0	1	2	3**

* descriptive evaluation (2), concept analysis (1)

** consultation, audit/evaluation, concept analysis.

2.2 The concept of CPD

Through the course of my work I was aware that, over time, a variety of terms have been used to represent education following qualification. For example, at various times at Middlesex University this has been referred to as post-registration education, post-qualifying education and CPD. It was important to reflect this variation in the literature search and to ensure that it included a variety of synonyms.

A useful starting point was Gallagher's concept analysis. She argues that the differentiation between continuing education and other CPD-related terms remains indistinct (Gallagher, 2007: 468). Gallagher uses the term 'continuing education' but argues that a 'confusing number of terms exist', including continuing professional development, continuing professional education (CPE) and lifelong learning (LLL), and that essentially they may be viewed as the same concept.

In line with Gallagher's analysis, a variety of terms was found to be used in the literature and there was no consistency found in relation to a term being associated with a specific type of CPD activity. Gould et al. (2007: 603) use the term 'continuing professional development'. Nurses working in three acute Trusts in London were asked to complete a questionnaire about their CPD activities. 'CPD' in this study was associated with 'long and short courses, study days and other learning opportunities', although what these might be is not specified. Banning and Stafford (2008: 178) also use the term 'CPD' in their study of community nurses' perceptions and experiences of CPD and suggest that it includes formal and informal elements, 'formal' being study days and courses, and 'informal' being

activities as varied as reading journals, networking, being part of a practice development projects and clinical supervision. Tame (2011) acknowledges that 'CPD' and 'CPE' are used interchangeably. She identifies 'CPE' as being a specific element within a wider CPD framework. In her study, relating to the perceptions and experiences of peri-operative nurses' CPE, 'CPE' relates to formal university study leading to an academic qualification.

The literature did not always specify the nature of CPD in which participants were engaged and, where it did, there were a variety of interpretations ranging from mandatory updates, in-house provision (study days or courses run by Trusts rather than universities), academic provision ranging from stand-alone modules through to undergraduate and postgraduate degrees. I noted the absence of discussion of research constituting CPD.

In the professional body literature there is no specific definition of what constitutes CPD, nor does it specify what should be learned. The specifics relate to the number of hours of study and practice that should have taken place over the previous three years. The NMC Prep (CPD) standard requires registered nurses and midwives to have engaged in 35 hours of CPD in the previous three years and, along with the Prep (practice) standard, is a re-registration requirement.

The NMC discusses CPD in the context of learning activities in the broadest sense and specifies neither the nature of the learning nor what should be learned. Rather, it is the responsibility of the individual practitioner to engage in such CPD activities that they believe are necessary to maintain and develop their practice for the whole of their professional lives. Similarly, the HCPC relates CPD to a range of learning activities and defines it thus: 'a range of learning activities through which health and care professionals maintain and develop throughout their careers...' (<http://www.hpc-uk.org/>)

Middlesex University's range of healthcare CPD provision in the context of the literature is broad, comprising credit programmes of study at undergraduate (UG) and postgraduate (PG) level, stand-alone modules (UG and PG), and non-credit provision known as non-credit-bearing courses (NCBC) in the form of single or multiple study days. It also encompasses bespoke, Trust-specific project work usually involving the development of education provision in a specific context. At first glance, Middlesex CPD provision is not as broad as some described in the literature and perhaps is most closely associated with the formal type of CPD described by Banning and Stafford (courses and study days), although they do not specify whether the courses are associated with acquisition of academic credit. There is, however, another dimension to Middlesex's CPD provision. It enables students to gain academic credits by engaging in informal CPD activities such as

those described by Banning and Stafford (2008) or Gould et al. (2007) and includes work-based activities. Through the development of a portfolio that identifies and reflects on areas of learning, students are able to transform informal learning into formal learning.

Reviewing the CPD literature helped to clarify the concept of CPD for the purposes of the two elements of the study in the context of the provision available at Middlesex. For the purposes of the student experience study, I made the decision to focus on literature pertaining to higher education-accredited course provision, partly because this comprised the majority of our CPD provision and because of ease of access to students. The experience and perception of students accessing Trust-specific bespoke provision or non-credit-bearing study days or courses designed by the University was felt to be slightly different from those on modules or programmes. Typically, bespoke provision and other non-credit bearing courses do not include summative assessment and the associated acquisition of FHEQ credits. In addition, provision is often delivered on Trust premises rather than at the University. Whilst it can be argued that the students undertaking bespoke provision or non-credit-bearing course delivered at the University are engaged in CPD activity, their experience is likely to be different from those taking programmes or modules validated by the University and developed, delivered and monitored under University policies and regulations. For the purposes of this study, healthcare CPD was defined as the study of stand-alone modules and programmes at undergraduate or postgraduate level, leading to the award of academic credit and taught on University premises. By necessity, the concept of CPD for the stakeholder–curriculum study had to be much more open and flexible, in part determined by the stakeholders themselves.

The concept of CPD seemed to me a mega or macro-concept within which the key stakeholder and healthcare CPD themes in the literature were located and conceptualised. Three further themes relating to the CPD were identified in the literature: perception, motivation and participation; impact on practice; and teaching and learning strategies. Within each it is possible to identify a stakeholder element. Employer-stakeholder influence and power in terms of access to CPD emerges as a significant aspect of the CPD process for the student-stakeholder. The role of the employer-stakeholder in facilitating change in practice following participation in healthcare CPD is discussed in the context of CPD impact. Finally, teaching and learning strategies are discussed as a strand of the healthcare CPD literature. Also discussed are the role of academic-stakeholder in curriculum design, the engagement of the student-stakeholder as an active or passive user and the benefits of employer-stakeholder involvement in healthcare CPD provision, in co-operation with the student and the University.

2.3 Healthcare CPD students' experiences: Perception, motivation and participation

Key areas addressed within this theme are healthcare practitioners' perceptions and beliefs about the purpose of CPD, and the array of benefits and challenges associated with accessing, participating and completing CPD provision. In terms of perception, the literature indicates that CPD is viewed in a positive light by nurses and midwives (Timmins, 2008; Hayajneh, 2009); it serves as the motivation for participation. Reasons for participation are varied. Bahn (2006) and Cooley (2008) both discuss how nurses in their studies feel that CPD is important in terms of 'keeping up' and not being left behind, especially when working with student nurses whose pre-registration education is set at a higher level than their own. This is an issue that recurs each time the level of award following completion of a pre-registration nursing programme is raised, and it resonates with my experience both as a post-registration nursing Dip HE and a top-up degree programme leader.

Regarding keeping up to date (as opposed to keeping up), the acquisition of new or enhanced knowledge was also identified as a motivating factor (Bahn, 2006; Gould et al., 2007; Cooley, 2008) that in turn is associated with patient safety or improved patient care (Bahn, 2006; Joyce and Cowman, 2007; Gould et al., 2007; Cooley, 2008; Munro, 2008). Participation in CPD was also associated with personal and career development (Gould et al., 2007; Hayajneh, 2009). The potential of CPD to impact positively on service delivery and to benefit the employer and the organisation is discussed by Munro (2008) and Gould et al. (2007). Munro, using a maleficence–beneficence continuum, argues that CPD benefits employers more than individuals, particularly when funding for CPD is sourced from somewhere other than employers, including of course individuals themselves.

Negative perceptions and impact on motivation and participation

In many studies actual or potential barriers impact on the motivation and the ability to effectively participate in CPD. Two systematic reviews were particularly helpful in summarising the literature on barriers and deterrents: by Schweitzer and Krassa (2010) and by Santos (2012). Barriers can be identified at three points in the CPD 'journey': getting on; being on; and following completion.

Getting on

A factor that may inhibit access is a lack of study time in which to attend CPD, resulting in not attending or the need to do so in personal time (Schweitzer and Krassa, 2010). When

not funded by an employer or workplace, the cost of CPD is also identified as a barrier (Schweitzer and Krassa, 2010; Santos, 2012). Workplace location is another factor for those working in rural areas, identified as a key theme in the Australian literature and associated with professional isolation (Jukkala et al., 2008; Hegney et al., 2010).

Employers play a pivotal role in relation to starting the CPD journey. Gould et al. (2007) and Munro (2008) discuss the gatekeeper principle. In this role managers play a key part in the decision-making process in terms of who is supported to undertake CPD, what type of CPD is permitted and whether it is associated with study time and funding. Also significant is the employer's perception of the link between appraisal, opportunities for staff development and access to CPD. Where appraisers fail to make a link, healthcare staff take a negative view of the appraisal process and perceive it to be a token exercise that is undervalued by the appraiser (Berridge et al., 2007).

Being on

Undertaking CPD studies presents further challenges. The dominant theme in this respect is the pressure of combining work, personal and domestic commitments with study, and the impact this has on personal and family life (Cooley, 2008; Gould et al., 2007; Schweitzer and Krassa, 2010). An interesting dimension of the negative perceptions whilst undertaking CPD is Tame's concept of 'secret study'. In her study, participants reported keeping their CPD study activities secret from colleagues and managers in the context of a negative or even hostile workplace culture and 'cultural discourse' regarding academic study (Tame, 2009).

Completing

Following completion of a CPD event, a significant barrier is the inability to apply new knowledge, change practice and enhance service delivery (Santos, 2012). Gould et al. (2007) suggest that this, too, is determined by the workplace culture and specifically may be limited by the manager.

In the context of the planned project I noted that there seem to be little literature on the experiences of healthcare CPD students in the HE system. Tame's 2009 study of peri-operative nurses' perceptions and experiences represents the exception. Nurses in this study reported enjoying their student status and discussed the value they attached to their student card. This lay in making them feel young and, significantly, was an outward symbol of 'acceptance into the university and reinforcement of their academic ability'.

There was a status attached to notion of 'student' that was higher than that attached to either 'nurse' or 'woman' (Tame, 2009: 259).

Compared to the literature relating to perception, motivation and participation, there are few studies on the impact of CPD on the individual, on practice, on service delivery and on patient care. Satisfaction and pride on successful completion of academic work is an important feature in the literature. The notion of confidence is also vital, along with other aspects of professional development. Tame (2009) describes how participants in her study reported personal and professional changes as a result of accessing CPE; the acquisition of knowledge was associated with confidence that, in turn, resulted in improved inter-professional relationships.

2.4 Impact of healthcare CPD on practice

Key issues within this theme are the impact of CPD on the individual, on clinical practice and on the organisation, and the significance and influence of employers/managers.

Whilst personal and professional development following completion of CPD was reported, there was agreement that completion of CPD did not necessarily result in changes in organisational practice or benefits to patients. Gijbels et al.'s systematic review of the literature adds weight to this view, finding that there is evidence of learner reaction, changes in attitude and acquisition of knowledge and skills. There is also some evidence of change in behaviour, but limited evidence of change in organisational practice or benefit to patients (Gijbels et al., 2010).

Where changes in practice were reported, it is argued that the attitudes of supportive colleagues (and professionals) and peers are more likely to enhance positive change than policy drivers. Lee (2011) emphasises the importance of personal drive and enthusiasm as additional drivers for change. Only one study links teaching and learning strategies to outcomes. Forsetlund et al. (2009), in a systematic review of 81 trials involving 11,000 HCPs, find that educational meetings either alone or with other educational interventions improve professional practice and crucially have a small positive effect on health outcomes.

It is somewhat surprising that there have not been more studies relating to measuring impact. In a climate of reduced funding for CPD, alongside previously discussed concerns about patient safety and nursing care and the increasingly competitive market in which CPD operates, I would argue that impact (on patient outcomes, on service delivery and organisational development) should or will become a key criterion in determining which

organisations receive CPD commissions. However, a major factor in this is something over which healthcare CPD academics have little control—the influence of managers in facilitating the implementation of change following completion of CPD activities. Where CPD has been seen to have a positive impact on practice is in the use of work-based projects that require employer engagement. This is discussed in the next section.

2.5 Teaching and learning strategies in healthcare CPD

This theme addresses the range of teaching and learning strategies used in CPD. The emphasis in the literature is on flexibility, recognition of the CPD student experience and matching approaches to meet these needs. The benefits and drawbacks associated with specific approaches are discussed. The isolation associated with certain types of learning strategies and the positive impact of employer engagement, particularly in the context of work-based learning, are features of this theme.

The need for flexible approaches to CPD teaching and learning in order to facilitate access in the light of the challenges and barriers that may hinder participation is emphasised in the literature (Presho, 2006; Randhawa, 2012; Southernwood, 2008; Glogowska et al., 2011; Wedlake, 2012), with a particular focus on the evaluation of ‘remote’ teaching and learning strategies. These are referred to variously as e-learning, online learning and distance learning using online materials (Randhawa, 2012; Southernwood 2008; Glogowska et al., 2011; Wedlake, 2010). Whilst e-learning and distance learning, where students were required to work through study material at a time, place and pace to suit themselves, were generally embraced, blended learning approaches appeared to be the preferred approach. Southernwood, for example, discusses distance learning using web-based online material combined with tutor facilitation (Southernwood, 2008). Glogowska et al. emphasise the importance of enabling students engaged in online CPD studies to ‘come together’ to create a community of inquiry (Glogowska et al., 2011). Achieving the right balance seems to be the key to providing CPD students with a positive learning experience, for example distance learning using online materials combined with opportunities for ‘class’ and tutor engagement. The engagement element may be face-to-face, classroom-based or online through synchronous or asynchronous discussion boards or chat rooms. It is important in reducing the perception of isolation that may be associated with distance and solitary learning (Wedlake, 2010).

Sobiechowska and Maish (2007) also discuss the importance of tutor input, in this case in the context of work-based learning (WBL). In this study the complexity associated with a

competency-led, self-directed WBL curriculum for students in full-time work is discussed. The challenges that faced these students in terms of generating evidence were such that the teaching and learning strategy was changed from self-directed, work-based to tutor-mediated, classroom-based where students were encouraged to draw on work-based experiences.

WBL is identified as an effective CPD strategy by Marshall (2012). Participants in her mixed methods case study responded positively to engagement in WBL projects. Analysis of focus group transcripts indicates increased confidence and credibility. Participants were perceived as experts by colleagues, having participated in projects designed to fill gaps in service provision and to meet local need. WBL projects were associated with tangible results and with the development of practice.

The WBL project approach in healthcare CPD is a strategy that straddles two areas, as discussed earlier. Firstly it adds weight to the impact argued above. Despite the paucity of studies on the impact of CPD, Marshall's study is evidence of the positive impact that WBL projects can have on service development, as well as individual personal and professional development. It also underlines the importance of employer/manager engagement in the CPD process through the tripartite relationship between employer, 'student' and HEI, a key feature of the WBL approach. The significance and power of the manager/employer was discussed above in relation to controlling access to CPD and in the implementation of change following completion of CPD activities. The WBL project approach addresses both of these issues in the sense that perhaps a manager's/employer's engagement with the CPD process might be improved if able to a) participate actively in the process through joint identification of work-based projects, b) see the potential benefit to the organisation and c) see the tangible benefits to the service and to the individual following completion of the project.

My view is coloured by my own experience of WBL as a CPD doctoral student and as a CPD teacher with close ties to the Institute of Work Based Learning Studies at Middlesex University. Many of the students embarking on the top-up degree that I lead choose to take a WBL project module as part of their degree. When considering a WBL project, students often discuss the double win: completion of a project that they have agreed to commence—often as part of an appraisal—and the potential to gain academic credit and HEI support (tutor and learning resources).

2.6 The nature of stakeholders in the HE setting

Three sub-themes were identified in the literature:

- Stakeholder identification—who are the stakeholders?
- Stakeholder level of engagement or involvement in curriculum development
- Stakeholder perceptions of institutions.

Based on my experience, I had already formed a view on who the key stakeholders were in healthcare CPD (commissioners, funders, academics/HEI and students). This view is reflected in some of the CPD literature, where the importance of commissioner involvement in the CPD process was discussed. Southernwood, for example, discusses the need for HEIs to collaborate with commissioners to promote the uptake of web-based programmes (Southernwood, 2008). The importance of a collaborative relationship between purchasers and HEIs is also emphasised by Berridge, Kelly and Gould in terms of the need for HEIs to be more responsive and flexible in relation to purchaser/commissioner needs (Berridge et al., 2007).

From the healthcare CPD policy literature, at least three stakeholder groups are identifiable: the commissioner (the employer/manager); the purchaser, who may be the funding body; and the student and the HEI. A review of the wider literature on stakeholder involvement identified a broader range of stakeholders. Rhodes (2012), for example, discusses the potential for collaboration between service users, students and academics. Service users in this context are past, present or future direct users of healthcare services and may include those who choose to use specific healthcare services (*Service User and Carer Involvement*, 2004) or feel unable to use them and are defined as service eligible (www.leeds.ac.uk). Carers are defined as people providing unpaid support to a family, friend or neighbour, without whose help that person could not manage (<http://www.leeds.ac.uk/involvement/pages/about/about1.htm>). In relation to service users as stakeholders, whilst it can be argued that they are indeed important stakeholders in healthcare CPD, this should be seen in the context of Rhodes' argument that, based on the literature, there is actually neither any clear definition of user involvement, nor strong evidence that the involvement of users in healthcare education is either effective or desirable (Rhodes, 2012). This is an interesting position to take, given the emphasis that the professional body, the NMC, places on the importance of service user involvement in most if not all aspects of pre-registration nurse education. This was also a useful paper in the sense that it helped me to think about the HEI and its academics as separate entities with potentially different agendas.

Chapleo and Simms' (2010) case study of a UK HEI identified multiple stakeholder groups: students, subdivided into potential, actual and alumni; student-related groups (parents and schools); local and national businesses; university staff (academic and non-academic); academic and research bodies (eg QAA, HEFCE); regionally focussed bodies such as local government and local community forums; and finally the Government, including departments such as the Department of Education. In all, thirty types of HEI stakeholders were identified. Meyer and Bushney's 2008 paper also took a broad HE approach and identified a total of 18 stakeholders in their work on developing a multi-stakeholder model of excellence in the HE curriculum in post-apartheid South Africa (Meyer and Bushney, 2008). The involvement of multiple stakeholders is also discussed by Keogh et al. (2009). Although their study took place in New Zealand it is perhaps the most useful in that its focus is the development of pre-registration nursing in an HE context. Even with the focus narrowed to nursing curriculum development, seven stakeholder groups were identified.

Few papers discuss the involvement of stakeholders collaborating on broad strategy development; instead, stakeholder engagement or involvement in healthcare education is discussed in the context of specific course or programme development. Meyer and Bushney's multiple stakeholder–curriculum development model involving six stages within three phases is perhaps the most useful, identifying the need for a focussed effort to liaise with a wide range of stakeholders and to ensure their viewpoints are represented as part of the curriculum development and design process (Meyer and Bushney, 2008).

Two papers focus on the concept of value and stakeholder involvement. McClung and Werner in 2008 and Swanson in 2009 both suggest that a university must be perceived by its stakeholders as providing value in the relationship, and that it must understand what constitutes value to an individual stakeholder. At the same time it should invest resources in educating stakeholders about the value that it generates (Swanson, 2009). This is an important concept that can be applied to stakeholders involved in healthcare CPD. Stakeholders' perceptions of the university are of key importance. In the context of a competitive market for the provision of healthcare CPD the stakeholders' perceptions of the value that a particular university offers can significantly impact on the partnership relationship and commissioning, or purchasing behaviour. Stakeholder involvement in curriculum development activities could be perceived by stakeholders as adding value to the relationship. At the same time, asking stakeholders about their views on the factors to be taken into account in the development of healthcare CPD gives the university the opportunity to establish what is important to key stakeholders and subsequently to demonstrate this through the curriculum planning process.

Reviewing the literature confirmed my view of the importance of understanding stakeholders' attitudes, values and needs in curriculum development. The wide range of possible stakeholders in the HE context was helpful in reminding me in the first instance to consider the widest range of stakeholders before deciding which stakeholders were key to the consultation process and to be part of the collaborative group. Consideration of the literature enabled me to answer the question: Who are the key stakeholders in healthcare CPD and which of these will be asked to participate in the study?

2.7 Summarising the literature and concluding comments

I have argued that there are five themes in the literature relating to healthcare CPD: the concept of CPD; healthcare CPD students' experiences—perception, motivation and participation; the impact of healthcare CPD on practice; teaching and learning strategies in healthcare CPD; and the nature of the stakeholders in the HE setting. The literature on stakeholders in HE and CPD was useful in that it enabled me to think about the varying strength of stakeholder power and influence, and the impact this might have on my study. The concept of value was useful in thinking about how this would affect the stakeholders' perceptions of the university and determine the stakeholder–university relationship. The importance of the university's understanding what constitutes value to the stakeholders was pivotal to my thinking. It seemed to me that the stakeholder–curriculum line of enquiry could be important in shedding light on how stakeholders in my study attach value to the university.

Summary of themes from the literature review

The literature gave me some insight into the different dimensions of healthcare CPD provision and was useful for insight into aspects of the healthcare CPD student experience. What seemed to be missing, however (with the exception of Tame's work), was a discussion of the healthcare student experience in the context of higher education. This suggested to me that one, if not both, lines of enquiry had the potential to add to the existing body of knowledge.

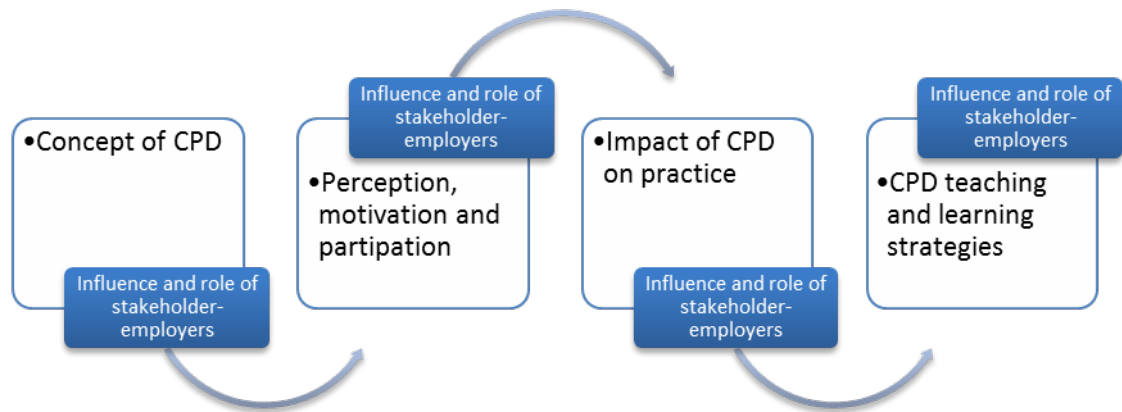


Figure 2: Summary of themes from the literature review

The themes identified in the literature enabled me to set parameters and to clarify definitions and meanings. CPD in the context of this study included any course of study related to health and/or social care undertaken at Middlesex University that resulted in the award of academic credit. Credit may be achieved through completion of a single module or a programme of study at undergraduate or postgraduate level. It excludes non-credit bearing provision in the form of single or multiple study days. I decided that the study participants would comprise qualified nurses, midwives and social workers, the last whom I intended to include in order to explore whether there was a difference between the healthcare and the social care CPD experience, undertaking a course of study at Middlesex University as defined above.

The next chapter focusses on research design. I consider different paradigms and research approaches. I consider the research questions and reflect on which paradigm and approach is the best fit. Reasons for my choice of approach are outlined and issues of quality are considered.

Chapter 3 From Research Question to Research Design

3.0 Introduction

In Chapters 1 and 2 I discussed how the two areas of concern, that is, the lack of understanding of the healthcare CPD students' experience and a lack of a collaborative, coherent set of curriculum principles to underpin the development of their education provision, were identified through my work as a DoP between 2007 and 2010. In Chapter 1 the project and the problem were set in a wider politico-economic, health and education policy and professional context. In Chapter 2 key themes were identified from the literature relating to CPD and stakeholders in HE, nursing education and health contexts. In Chapter 3, the key areas to be addressed centre on establishing which paradigm and research approach are best suited to the research question. The themes established and developed in Chapters 1 and 2 in relation to positionality, personal learning and the role of the insider will be discussed in the context of different research approaches. This chapter also marks the beginning of a degree of method uncertainty. This thread runs through the chapter and continues into the next.

3.1 Framing the problem

In attempting to frame the problem I spent time reflecting on my work and my role and my perception of the organisation's relationship with and approach to CPD students in comparison to full-time undergraduate and postgraduate students. As a result I was able to articulate what I felt were the issues underpinning the nature of the CPD student experience. From my personal perspective I felt real concern that the CPD students' voice was unheard, their views were not taken into account and they themselves were not fully visible. As a result, policies, procedures and regulations did not always meet the needs or reflect their requirements. Neither their views nor those of other stakeholders were fully taken into account in the context of CPD curriculum development strategy and subsequent curriculum design. Further consideration of the problem suggested to me that the invisibility and inaudibility and the lack of representation of the full spectrum of stakeholder views was linked to concepts related to inequality of opportunity.

It is through this frame that the research questions were developed. These were:

- What is the nature of the student experience for healthcare CPD students studying at Middlesex University?

- What factors do key healthcare CPD stakeholders believe should be taken in account in the development and planning of education provision for PQ healthcare CPD students?

In the research literature it is suggested that for any given problem a researcher wishes to explore, depending on their perspective there are a number of options in terms of the research strategy to be adopted. As an example, Denscombe (2003) discusses the investigation of homelessness. He suggests that this could be studied from the perspective of what it is like to be homeless; that is, the subjective reality of homelessness. Alternatively, the extent of homelessness could be measured or the causes of homelessness explored. It is important to be clear about exactly what it is that is being studied and what the researcher wants to explore and find answers to, so that the appropriate strategy is chosen. The overarching focus of my project was enhancing the student experience. Within this project there were two lines of enquiry. The first was directed towards uncovering meaning, enhanced understanding and subjective perceptions of the CPD student experience from the students' point of view. The second aspect also related to subjective perceptions, but this time from a wider range of stakeholders (including healthcare CPD students), all of whom had a valid interest and stake in the issue of curriculum strategy development, design and delivery.

Neither line of enquiry was based on the need to measure or establish a causal relationship between variables so, whichever strategy was going to be adopted, I was clear from the start was that the project would not be located within a positivist paradigm. Holloway and Wheeler (2010) summarise the positivist approach as a science based on the belief in universal laws, attempting to present an objective picture of the world. Green and Thorogood (2009) discuss positivism as a philosophy with a focus on three core elements: empiricism or observable phenomena; unity of method of enquiry; and value-free enquiry—that is, science as separate, objective, rational and neutral.

Holloway and Wheeler (2010), Green and Thorogood (2009) and Cohen et al. (2007) (and many other writers) describe the rise of the anti-positivist movement and the development of the alternative interpretative paradigm in response to the belief that positivism was neither useful nor appropriate for the study of people and behaviour. Cohen et al. (2007: 11) capture the essence of this view: 'Where positivism is less successful, however, is in its application to the study of human behaviour. Here, the immense complexity of human nature and the elusive and intangible quality of social phenomena contrast strikingly with the order and regularity of the natural world.'

The core features of the interpretative or naturalistic approach are compared and contrasted with the positivist approach in the table below.

Table 3: Comparison of core features of the positivist and interpretative paradigms

Interpretative	Positivist
Multiple realities	Single truth, one reality
Reality socially constructed	Objective reality
Insider/reflexive	Outsider/unbiased
Value laden	Value-free
Subjective	Objective
Qualitative focus	Quantitative focus
Context bound	Universal applicability
	Generalisable findings.

3.2 The challenge of competing paradigms

One of the challenges of locating the research within a particular paradigm is the different ways in which the paradigm debate was discussed in the literature. In some texts it is argued that there are two main paradigmatic positions; positivist and interpretative, as discussed above. In others three paradigm positions are discussed. The third has evolved as a result of the identification of weaknesses associated with the interpretative position. A key criticism is that, whilst it is acknowledged that the development of the interpretative position was a direct result of the identification of limitations of the positivist position, interpretativists have moved too far in the opposite direction. Whilst a positivist position is located in and criticised for its universal, one-world approach, the micro, local, contextual approach within the interpretative position has been criticised for ignoring the socio-political and power context within which behaviours take place. As a result, a third paradigm—critical theory—has developed, based on the notion of participation and change (Williamson et al., 2012), in particular emancipation and empowerment (Cohen et al., 2007).

Critical theory as the third paradigm

What was attractive about this 'third' paradigm for me was the way it resonated with the way in which I located the healthcare CPD student 'problem'. I liked the idea of setting the project within an explicitly socio-political context. As I discussed in Chapter 1, developments in nursing education over the last twenty years can be characterised in two ways: marketisation and a gradual move into HE. It is impossible to discuss this without reference to the socio-political context within which these developments took place, as the context is obviously affected by the political orientation of the government of the day. This was particularly pertinent to this project in that there was a change in government and a change in policy direction that directly impacted on Health Service and HE provision. This, in turn, impacted on healthcare education provision and certainly its CPD provision.

Cohen et al. (2007: 26) suggest that critical theory 'holds up to the lights of legitimacy and equality issues of repression, voice, ideology, power, participation, representation, inclusion and interests'. This perspective seemed to resonate with Meerabeau's views on the position of nursing in HE and how it is perceived, particularly by more established disciplines such as medicine, especially in respect of voice and power. More specifically, it seemed to me that the purpose and aim of this project could fit neatly into this paradigm, given the focus on enhancing the healthcare CPD student experience, by enhancing their visibility and audibility (student experience line of enquiry), encouraging their participation and ensuring that their views as key stakeholders were represented (curriculum strategy line of enquiry).

The process of decision making involved repeatedly returning to the question and the 'frame' in order to establish an appropriate paradigmatic match. Although I was sure what the project was not, that is, not positivist, I still needed to be clear about which, if any, of the approaches of the interpretative paradigm or critical theory paradigm would best suit the project and its lines of enquiry. It seemed to me that both lines of enquiry could fit the interpretive tradition insofar as what I wanted to explore was the subjective perceptions of key stakeholders. It was a particularly good 'fit' for the student line of enquiry. However, for the stakeholder–curriculum line of enquiry, there was a possible added dimension in that this was much more research and practice focussed. In addition the beliefs, perceptions and actions of key stakeholders for this line of enquiry needed to be seen and interpreted within a socio-political context—the marketisation discussed above. I envisaged that the result of consultations with key stakeholders would be a draft Curriculum Development Strategy Document that would then require 'testing' in practice. This suggested a two-phase process, and a research approach located within critical

theory therefore seemed to fit this line of enquiry. The epistemological and ontological positioning adopted for a particular study, it is argued, should influence the methodological approach and this was the next level of decision making that was required.

3.3 Methodological approaches: Student experience line of enquiry

For this line of enquiry, in order to gain the broadest perspective on this experience I decided to use two data collections methods that would enable me to build a profile of the healthcare CPD student in terms of demographic characteristics and to gain insight into the nature of their participation in healthcare CPD study.

I planned to design a questionnaire in order to collect demographic, contextual and short narrative data relating to the student experience. Denscombe (2003) argues that whilst questionnaires are best used with large numbers of respondents, one advantage is that they can be used across a wide spectrum of research situations and can elicit both facts and opinions; this was exactly the purpose of my questionnaire. It was my intention to obtain factual data to highlight the demographics of the student group and to elicit their opinions about the student experience. I was also attracted by the relative ease of analysis of pre-coded data (Denscombe, 2003: 161).

This demographic, context-setting and narrative data, however enlightening, would still only provide superficial data that would need to be enhanced by more in-depth data on the nature of the student experience in HE. I decided that a focus group would serve this purpose. Chiu (2003: 174) suggests that focus groups can function as an instrument for understanding the concerns of participants, whilst Green (2007) discusses the benefits of the focus group in providing an opportunity to research people's experiences and attitudes. In addition she discusses the advantage of the focus group in overcoming the power imbalances between the researcher and research participants that may be present in one-to-one interviews. This was an important consideration, given that the group I was most easily able to access comprised my own degree course students. I was also influenced by previous experiences of one-to-one interviews and the time needed to transcribe them. Crucially, the focus group as a method of data collection would enable me to obtain rich descriptions of the healthcare CPD student experience, thus meeting one of the key criteria for an interpretative study. Data collection for this line of enquiry was therefore conceptualised as two phases, moving from superficial to deep.

I initially conceptualised this as a mixed methods approach. My initial enthusiasm for this approach was somewhat curtailed when it became clear that true mixed methods had to

include quantitative approaches. Mixed methods is described by some as the third major paradigm or research approach (Burke Johnson et al., 2007) or the third methodological movement (Doyle et al., 2009). Both sets of authors agree with Denscombe (2008) that mixed methods research involves the use of qualitative and quantitative methods in the same research project.

Burke Johnson et al. (2007) describe a 2003 study carried out by Onwuegbuzie and Teddlie that reports on the definitions of mixed method research provided by experts in the field. The prevailing view (15 of 19) was that the 'mixed' in mixed methods relates to mixing of quantitative and qualitative methods. Mertens and Hesse-Biber (2012) concur with this approach. In their interpretation of the benefits of mixed methods they state that the method is a way of ensuring that marginalised voices are heard by enabling data collection methods that otherwise would not have been deemed appropriate. I particularly liked their idea of 'subjugated knowledge being made visible' (Mertens and Hesse-Biber, 2012: 78). Given the interpretation of mixed methods above, and that this line of enquiry and the data collection methods within were qualitative, it would be difficult to classify my work as mixed methods. Only Onwuegbuzie and Teddlie's study (Burke Johnson et al. 2007), suggests that mixed methods might also relate to within-paradigm mixing.

I started to explore the possibility that, although it could not be viewed as mixed methods in terms of paradigmatic focus, the student experience line of enquiry could meet the criteria for within-method triangulation. At the same time it would acknowledge the limitations stemming from the location of the research within one paradigm and its inherent weaknesses.

Triangulation is an important concept in qualitative research and a key feature of qualitative research literature. Defined by Holloway and Wheeler (2010: 308) as the process by which the phenomenon or topic under study is examined from different perspectives, triangulation is considered to be an important factor in the assessment of quality of a research study. Holloway and Wheeler suggest that the use of triangulation contributes to establishing validity in a project that, in turn, is associated with quality and rigour.

Denzin (1978, cited in Burke Johnson et al., 2007) describes four types of triangulation:

- Data triangulation through the use of multiple data sources, including data from different groups or at different times or in different settings
- Investigator triangulation where more than one researcher is involved in the study

- Methodological triangulation through the use of two or more methods to answer a similar question
- Theoretical triangulation—the use of several theoretical interpretations in study in order to find ‘best fit’.

In addition he also identifies within and between methods triangulation (Burke Johnson et al., 2007: 114).

In this student experience line of enquiry it would be possible to triangulate findings from questionnaire and the focus group. I finally came to the conclusion that this line of enquiry could be described as a qualitative study, using within-method triangulation.

3.4 Methodological approaches: Stakeholder–curriculum line of enquiry

For this line of enquiry, having already acknowledged my preference for a research approach located within critical theory, the next key decision centred on the approach I should chose. The literature indicates a range of approaches within critical theory. For example, Cohen et al. (2007) suggest that the critical paradigm comprises critical theorists, action researchers and practitioner researchers. Herr and Anderson (2005: 10) focus on the AR approach and use ‘action research’ as an umbrella term within which there are several approaches, with ‘multiple traditions’ and ‘distinct scientific communities that are in constant evolution’. Given the multiple traditions and approaches, I was inclined to agree with Coghlan and Brannick (2005: 14) that in AR there is ‘a bewildering array of activities and methods.’ Important to AR, however, is the focus on ‘simultaneous action and research in a collaborative manner’. The ‘bewildering array’ of AR approaches is detailed in the table below.

Table 4: Key features of the main action research approaches

Action Research Approach	Key Features
Traditional action research	Based on the work of Lewin. Collaborative: researcher and client. Problem solving focus. Action cycles of planning, action, observe evaluate (reflect).
Participatory action research (also emancipatory action research)	Community focus. Egalitarian participation. Transformational. Empowerment.
Action learning	The task as vehicle for learning. Based on the work of Revans. Learning for self in company of others. Learning with and from each other.
Action science	Based on the work of Argyris. Cognitive processes of individuals' theories-in-use and impact on organisational learning.
Developmental action inquiry	Based on the work of Torbert Links ability to engage in collaborative enquiry to stages in ego development
Co-operative inquiry	Based on the work of Heron and Reason People engaged as co-subjects (in experience phases). People engaged as co-researchers (in reflection phases).
Clinical inquiry	Based on the work of Schein. Trained helpers as organisational clinicians. Focus on pathologies.
Appreciative inquiry	Based on the work of Cooperrider. Appreciative focus at organisation level on what already works. Four phases: discovery, dream, design, destiny.
Learning history	Based on the work of Roth and Kleiner Learning history document produced by participants with a focus on change and presented to stakeholders. Stakeholders add their perspective to the narrative. Learning historians add their reflections and analysis, leading to further discussion within the organisation.
Reflective practice	Based on the work of Schön. Systematic critical reflection by individuals on own practice. Rarely an organisational focus
Evaluative inquiry	Based on the work of Preskill and Torres. Inquiry process to generate organisational learning.
Adapted from Coghlan and Brannick (2005: 14–20)	

3.5 Action research: Rationale for choice

For the stakeholder–curriculum line of enquiry, I chose to adopt an approach that probably most closely fits the traditional AR approach outlined above. Most writers on AR agree that its core, shared concept is its focus on a combination of action and research that makes it suitable for use in situations where change is the desired outcome. Other features that made it an appropriate approach are its focus on critical reflection, reflexivity (also a feature of research based in the interpretative paradigm), links to the researcher/worker role, professional development and collaboration. The focus on partnership and collaborative democratic practice was a key factor that I felt made it appropriate for this enquiry. This line involved a range of stakeholders and it was important that the participants were all involved in the process, and that everyone's view counted. For me, this was particularly important in the light of my views and beliefs about CPD students being invisible and inaudible, and that curriculum strategies had been written on the basis of the 'top-down' few rather than the many stakeholders. The approach is also situationally relevant, with both the 'diagnosis' and the 'therapy' being located strictly within a specific context yet that others can learn from and possibly use or apply to their own practice (McNiff and Whitehead, 2010). The focus on action and research related to the perceptions of healthcare CPD students would, I hoped, contribute to organisational learning and ideally result in a change in School or University practice. What was also attractive about AR was timing. Some authors suggest that AR is a lengthy, protracted approach, but this is not necessarily so. Each cycle has the potential to produce relatively immediate change.

A key influence in the choice of this approach was the echo of and similarity to the nursing process and the focus on phases within a cycle. This was the core of my everyday clinical practice when working as a hands-on healthcare practitioner engaged in direct patient care. I liked the idea of being a healthcare education practitioner and using an approach to education practice change mirroring the model I had used to guide my healthcare practice and my classroom teaching.

Table 5: Nursing process and action research phases compared

Nursing Process Phases	Action Research Phases
Assessment/problem identification	Diagnosis
Action planning	Planning
Implementation	Implementation of action strategy
Evaluation	Evaluation, reflection and planning

(Note: Various models exist depicting the cyclical nature of AR)

I was inclined to support the view of Williamson et al. (2012) who suggest that AR is the ideal approach to address workplace problems and to raise professional standards in the context of a real world problem. This articulated within my project, which was also real world, problem-focussed and would, I hoped, result in improved practice. I envisaged at least two cycles of AR, one based on the need for a multi-stakeholder consultation phase leading to the development of a draft Curriculum Strategy Document, and the second based on the need for the document to be tested.

As discussed in Chapter 2, based on my experience I had already formed a view about who the key stakeholders were in relation to healthcare CPD (commissioners, funders, healthcare academics and healthcare CPD students) and therefore who the key participants were likely to be in this line of enquiry. A strength inherent in using a range of data sources and data collection methods is that findings from one method may be used to support and substantiate findings from another or to provide greater depth of understanding and credibility (Williamson et al., 2012).

The stakeholders finally identified for the stakeholder–curriculum study were the Strategic Health Authority; NHS Trust commissioners; healthcare academic teaching staff and CPD students. I excluded patients on the basis that, arguably, ‘service users’ in this context were the healthcare CPD students as the past, present or future direct recipients of healthcare education, not the users of health services.

A wide range of data collection methods including qualitative and quantitative methods is permissible in AR, but what is important is that the method is appropriate for the particular line of enquiry and is informed by the research question (McAteer, 2013). For this line of enquiry, the most appropriate data collection method was the focus group. The research participants were key stakeholders in healthcare CPD with whom I had on-going relationships in a work context in my role as DoP, lecturer, or academic colleague. Rather than setting up specific and separate sessions for data collection I decided to use existing forums in the work setting to collect data for this line of enquiry. I envisaged these as a series of professional conversations about the factors to be taken into account in the development of a curriculum development strategy. It was not possible at this stage to identify which data collection methods would be used in second and subsequent AR cycles, but I was clear that the second cycle would probably focus on testing the draft Strategy Document and gaining feedback about its use from those who had piloted it. As such the most likely methods were focus groups or interviews. If interviews were deemed to be the most appropriate method for collecting data in Cycle 2, a key issue to be aware of was the interviewer/researcher dynamic. Green and Thorogood (2009) discuss the

importance of being aware of the power relationship between interviewer and interviewee. Denscombe (2003: 190) refers to this as the 'interviewer effect', where 'interviewer statements can be affected by the identity of the interviewer'.

In the context of the insider–researcher conducting an interview with a colleague, this was something that I needed to be aware of. That said, as would focus groups, interviews would be likely to generate in-depth data that would shed light on the experience of using the curriculum development strategy although, according to Holloway and Wheeler (2010: 104), one of the problems of the interview is the potential for 'the participants' change of thinking over time'.

McAteer (2013) discusses advantages of audio recordings over note taking during an interview. It frees the interviewer from having to interrupt what is being said at intervals to take notes, and to respond and interact more effectively than in a note-taking situation. McAteer (2013), however, observes that a recorded interview has the potential to generate vast quantities of data and that the researcher should consider how to deal with an audio recording. I had not planned to use an external transcriber and knew, having transcribed interviews myself in the past, that this was likely to be time consuming.

Notwithstanding these potential difficulties, I decided that the focus group and or interview would potentially be the appropriate data collection method for Action Cycle 2 of the AR research.

From data collection to analysis

For both lines of enquiry—given the type of data being collected—the dominant method of analysis was likely to be thematic analysis of data arising from the narrative element of the questionnaire, the focus group(s), the professional conversations and from any interviews.

Thematic analysis is described by Green and Thorogood (2009: 198) as 'the most basic type of qualitative analysis' that enables the researcher to identify categories and common themes arising from the data. Using this approach would enable me to immerse myself in the participants' feedback and interpret their accounts. It is the interpretive aspect of qualitative analysis that sets it apart from analysis in the positivist paradigm. In qualitative analysis it is essential that the impact of the researcher is recognised and taken into account. In interpreting the data the values, beliefs and attitudes, even the ethnicity, gender and other forms of identity of the researcher are likely to influence how the data is analysed and presented, and should be acknowledged as such. Denscombe (2003: 280) suggests that the advantages of qualitative analysis lie in the fact that the analysis is

grounded in reality, is rich in description and is tolerant of uncertainty. This, however, is weighed against the contextually specific nature of qualitative analysis. This means that generalisation is not possible. Denscombe also argues that the recognition of self in the interpretation of data means that findings should be interpreted with a degree of caution. Silverman (2013: 61) discusses the limitations of thematic analysis. He describes the process of 'finding key passages, choosing quotations and marking quotable themes with a highlighter' as 'mapping the woods', and suggests that what is missing from this approach is the fact that the interview or focus group is part of a conversation and that true meaning is captured through descriptions of interactions between participants in addition to descriptions of what was said. He does acknowledge, however, the risk of 'losing sight of the research problem' and the time-consuming nature of this type of analysis, conceding that at least 'mapping the woods... tells us something about a substantive phenomenon and thus offers breadth' (Silverman, 2013: 62).

3.6 Reflexivity, the insider–researcher and the relationship with significant others

As discussed above, a key and essential dimension of both interpretative research and critical theory is reflexivity. In contrast to the positivist position, where the researcher is said to assume an objective outsider stance in relation to the research, interpretative and critical theory paradigms argue that it is essential to recognise, acknowledge and be transparent about the role and impact of the researcher throughout the research process. A typical stance is reflected by Green and Thorogood, who argue that 'it is impossible to have a field for study that is untainted by values and impossible for the researcher to stand outside those values and subjectivities' (Green and Thorogood, 2009: 23).

According to Green and Thorogood, there are two aspects of reflexivity: the first involves critical reflection on the research in the context of why appropriate, why relevant, why now, what the context is. The other is the impact this has on the approach to the research, and what underpinning assumptions and values are brought to the research by the researcher. These have been addressed in this project report in Chapter 1. The second is further developed by requiring the researcher to consider the possible role and impact of the researcher, their values, beliefs and status. Holloway and Wheeler (2010: 9) discuss Finlay's account of typologies of reflexivity. Finlay (2002: 209) suggests that 'the process of engaging in reflexivity is full of muddy ambiguity and multiple trails as researchers negotiate the swamp of interminable deconstructions, self-analysis and self-disclosure'.

In order to make sense of ‘the swamp’ she identifies five types or maps of reflexivity and argues that, from these typologies, researchers can choose their preferred route. These are outlined in the table below.

Table 6: Finlay’s five reflexivity typologies

Type	Dimensions
Introspection	Exploration of own experience and meanings to further insight and interpretations.
Inter-subjective reflection	Awareness of the relationship between the researcher and the participants and impact on the research.
Mutual collaboration	Awareness that the research outcome is the product of the collaboration between partners.
Social critique	Awareness and acknowledgement of the power relationships and social position of researcher and the participants and impact this may have on the research.
Discursive deconstruction	Awareness of language and the potential for multiple meanings in the text.

Although Finlay suggests that researchers may choose a preferred route and that they have a preferred method of reflexivity, I also see that it is possible to move from one route or method to another at various stages in the research. In this way, for example, issues with and the origins of my personal values and beliefs discussed in Chapter 1 reflect the introspective element of reflexive typology. Inter-subjective reflection, mutual collaboration and social critique are addressed below in relation to the nature of the relationship between me and the stakeholder-participants in terms of the labelling of the nature of their involvement and the degree of power which each stakeholder holds. Issues relating to discursive deconstruction seem to me be more relevant to the project analysis phase of the project.

3.7 Inside or outside? The nature of collaboration and participation

The issue of the insider/outsider is central to all approaches to AR and, indeed, to all approaches. At one end of the spectrum is the position of the researcher in the positivist paradigm as an outsider and at the other the researcher as an insider. In general terms the insider–researcher may be defined as a researcher who engages in research from within a community or the organisation that, in the context of this project, is true for both lines of enquiry. In AR terms, however, Herr and Anderson (2005) argue that the researcher may adopt a position as either an insider or an outsider, depending on the type of AR. What is more important in their view, however, is the collaborative nature of the

relationship between the researcher and the participants. This seems to link to a degree with the Finlay's third dimension of reflection—mutual collaboration. Positionality within AR has been depicted by Herr and Anderson (2005) as a continuum on a scale of one to six, where the location of the researcher on the insider–outsider continuum is linked to a research approach ranging from 'the insider engaged in self-study' to 'the outsider researching the insider'. Table 7 below summarises this approach.

Table 7: The action research positionality continuum

1	2	3	4	5	6
Insider					Outsider
Insider (researcher studies own self/practice)	Insider in collaboration with other insiders	Insider(s) in collaboration with outsider(s)	Reciprocal collaboration (insider/outsider teams)	Outsider(s) in collaboration with insider(s)	Outsider studies insider
Traditions/research approach					
Practitioner research Autobiography Self-study	Feminist conscious-ness raising groups Inquiry/ Study groups	Inquiry/study groups	Collaborative forms of participatory action research (equal power relations)	Mainstream change agency: consultancies Radical change: community empowerment	University-based academic research on action research methods or action research projects

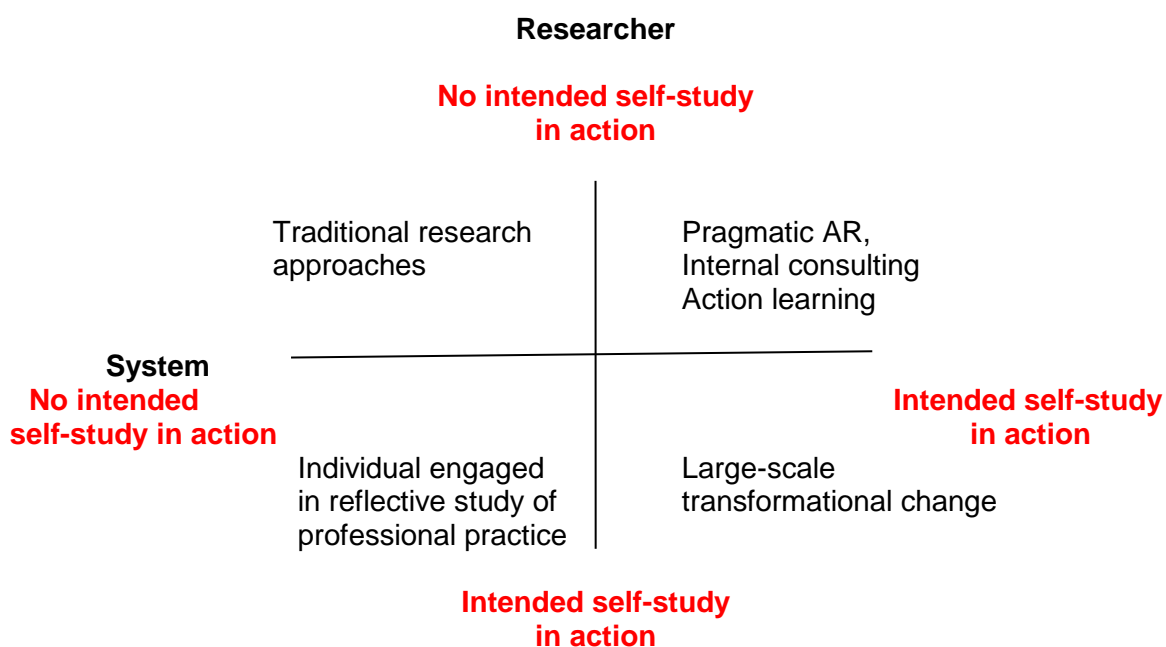
Adapted from Herr and Anderson (2005)

I felt it was important to be clear from the outset about the nature of the relationship between myself as an insider and the key stakeholders in the project. The status of the stakeholders as either insiders or outsiders and their relationship with me as a definite insider was a core issue that needed to be explored. In the context of healthcare CPD, four main actors with a stake in the nature of provision were identified: the academic staff (including me); the Trusts as commissioners; the SHA as funders; and the healthcare CPD students. At first glance, with the exception of the academic staff none of the other stakeholders could be construed as insiders as they are all part of a separate organisation, the NHS. However, whether this holds true depends to a large extent on how the stakeholders see themselves. In my view it was a given that the SHA and Commissioning Leads were very much part of a separate NHS organisation and, whilst still close partners with Middlesex University (particularly in the case of Commissioning Leads), were not insiders. For the student group this might be 'shifting sands' and represent what one of the lines of enquiry of the project was actually concerned with—CPD students' perceptions of themselves as part of the University (when students), or still associated with and belonging to the NHS organisation.

Herr and Anderson suggest that it is possible to assign different modes of participation category, depending on the nature of involvement of the stakeholders and the relationship of research and action on them. These range from co-option, where research and action are largely carried out 'on' local stakeholders, through to collective action where research and action are carried out 'by' stakeholder(s). At this juncture, my decision was to envisage the project as an AR project featuring the insider in co-operation 'with' local stakeholders. Together we would determine priorities for the direction of the curriculum development strategy based on their input, with responsibility lying with me as the insider for directing the process (Herr and Anderson, 2005: 40).

Locating myself within the project

Coghlan and Brannick (2005) suggest that it is important to differentiate between the researcher and the system in and on which the research is taking place, and to determine whether or not there is a commitment to organisational or self-study. Study of their useful quadrant continuum diagram helped me to locate myself and the University in this regard. Almost by a process of elimination, based on their definitions it seemed to me that the work that I intended to carry out was located in the lower left quadrant, that is, where there is intended self-study of the individual in action.



Adapted from Coghlan and Brannick (2005: 49)

Figure 3: Focus of researcher and system

It took me some time to arrive at this position as I was persuaded by some features described in the Pragmatic Action Research quadrant (top right) where the 'research is aimed at confronting and resolving a pre-identified issue' (Coghlan and Brannick, 2005: 50). The crux, however, was that in this quadrant there was system-focussed intended self-study in action but no researcher focussed intended self-study, which seems to conflict with the idea of critical reflection and introspection. Returning to the lower left quadrant and the concept of self-study in action, I decided the difficulty was in restricting my view of my professional activities solely to that of an insider–researcher and to the project work in which I was engaged. Whilst this involved an on-going process of critical reflection and reflexivity, this needed be extended. The key, I decided, was to link reflection and learning from all of the following activities—engagement in the project, the earlier review of learning and my past and current experience as a DoP—to a broader focus on my professional practice. It is the extent to which these three elements together demonstrate professional practice development in leadership in PQ healthcare curriculum in HE that is, I believe, achieved through the self-study approach outlined by Coghlan and Brannick (2005):

where the researcher is engaged in an intended self-study of herself in action but the system is not. She is engaged in simultaneously in a process of self-reflection and examining her own assumptions in action and learning about herself as events unfold. (Coghlan and Brannick, 2005: 52)

I have tried to capture this in the diagram below.

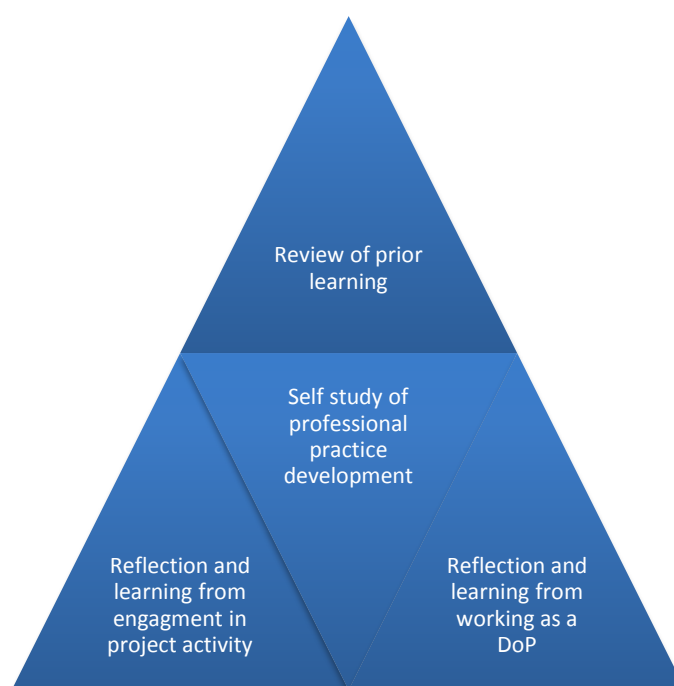


Figure 4: Elements contributing to the process of self-study of professional practice

In this section I have focussed on issues relating to the role of the insider–researcher, the relationship of the researcher with research participants and the organisation at which the research took place. The importance of reflexivity in qualitative research was discussed from the perspective of the application of different typologies to different phases of the research journey. The next section focusses on the ethical dimensions of the project and concludes with a discussion on issues of rigour in qualitative research in general, and then as applied to this project.

3.8 Ethical perspectives on the project

I think it is fair to say that my approach to research ethics was fairly prosaic, in that I was aware of and understood the principles underlying research governance in theory and in practice in relation to obtaining clearance for the project. My initial thoughts were that, in the context of both lines of inquiry, potential ‘harms’ to individuals stakeholders or stakeholder groups participating in the research were minimal. McAteer (2013: 87) warns against this approach. She suggests that gaining ethics committee approval is not simply a question of dealing with a set of procedures relating to ‘permissions’ and ‘anonymity’ and argues that researchers commonly take a ‘tick box’ approach to the process. It is important to recognise that the ethical dimension of research is a complex issue that is not simply about approval to proceed with a project, but a thread that weaves its way, and therefore must be considered, through all stages of the project.

The ethical dimension to this project was in my view about righting wrongs. It seemed to me that the ethical principles of beneficence and justice were of key import. I anticipated that the development of a Curriculum Strategy Document based on the views of stakeholders would be good for the organisation, the stakeholders, the students and the academic staff. Gaining insight into the healthcare CPD student experience would also be ‘beneficial’ in that, as a result, the organisation would be able to develop policies and practices that took their perspectives into account and just, in the sense that it was righting a wrong where the healthcare CPD students’ perspective was not properly represented and their voices not heard.

Beauchamp and Childress’ writings on justice were particularly useful in framing my thinking. They discuss the fair opportunity rule. This is based on and derives from John Rawls’ egalitarian theory of justice, and states that:

no persons should receive social benefits on the basis of undeserved advantageous properties and that no persons should be denied social benefits on the basis of undeserved disadvantageous properties and unfair discrimination. (Beauchamp and Childress, 2009: 249)

In the context of my project and my everyday work it could be argued that CPD students were denied social benefits. Whilst the 'undeserved' disadvantages are not quite in the same league as the 'disadvantages' of ethnicity, gender and sexual orientation, all of which are covered in UK by equal opportunities legislation, the principle still holds that as a result of their invisibility the CPD students are denied 'benefits' available to full-time students and, as such, the system is unjust. Beauchamp and Childress argue that the fair opportunity rule requires that benefits should be provided to 'ameliorate' a disadvantaged position and to ensure fair participation—in this case in the HE system. So in the context of the two lines of enquiry, student participation was of key importance to ensuring that a) they had a voice in terms of the factors to be taken in account in the development and planning of education provision CPD students, and b) that their opinions, views and perspectives on the nature of the student experience for CPD student studying at Middlesex were explored. Based on the outcomes of the project, 'benefits' could then be put in place.

Ethical considerations in AR

Williamson et al. (2012) discuss three ethical principles from an AR perspective and the specific issues relating to these that should be given consideration. In relation to *non-maleficence*, they suggest that a researcher should consider carefully how to ensure both participation without exploitation of participants and a democratic approach throughout the project, not only in terms of equality of contribution but ownership of the final product. At the outset I did not foresee this being a problem. I had planned that all stakeholders would contribute equally. However, having defined the CDS as one where I would be working co-operatively with participants (as discussed above in insider/outsider terms), I wondered whether there was the potential for me to drive the direction of the project and whether it might be problematic. In a sense, the direction was already set and the outcome already agreed, that is, a CDS. All participants were aware of this and what the final outcome was to be, so the issue about direction was less important than the issue of equality of contribution. It was therefore important to consider how all participants would have the opportunity to contribute equally.

The issue of ownership was more difficult. As the lead researcher, and as this project was part of my doctoral studies, I had always conceived the outcome or product as being 'owned' by me. This in itself was problematic in the context of AR where, in some approaches, the finished product or the project is owned equally by the participants. I took the view that the participants always knew that this was a Middlesex project and did not perceive themselves as 'owners'. Rather, they were collaborators—potentially powerful

collaborators at that. An interesting dimension that I touched in on Chapter 1 was the status and power of the stakeholders outside of the research. The purpose of the developing CPD was first and foremost about developing a realistic strategy that reflected the needs of key stakeholders. In terms of honesty and integrity, it was important to revisit the situational context within which the project was being implemented and to be open about why this was important. In my view we needed to implement this so that we could potentially maintain and increase our market share of CPD provision by demonstrating to our key stakeholders—those responsible for funding and commissioning—that our provision was fit for purpose, reflected the needs of key stakeholders and was based on collaborative working (the concept of partnership in healthcare education is highly valued). In this context, in terms of stakeholders and power it was not myself as a lead researcher or the University who held a powerful position but the Strategic Health Authority, the Commissioning Leads and the CPD self-funded students who, through their purchasing and commissioning activities, might or might not choose to commission provision or self-fund their studies through Middlesex University.

In writing this chapter I also felt that it was important to be honest about how the project work and its success or failure could, in my opinion, impact on my role as DoP. Like it or not, each year Middlesex University's position in the pan-London league table of HEIs (in relation to CPD) is published and each year a healthcare CPD contract is agreed with SHA/LETB. As DoP with responsibility for healthcare CPD, it was difficult not to feel responsibility for (and to believe that others agree) the size of the contract and our position in the league table (RAG rating). This project was the opportunity to provide evidence to key stakeholders of our commitment to CPD and, if the products and outcomes were positive, would have the potential to consolidate or improve the RAG rating that in turn could enhance the monetary value of future CPD contracts.

A final word on the role of the insider–researcher, the influence of the organisation, key stakeholders and ethical considerations is that at the forefront of my mind when planning the project, there was a question of what I would do if the results of any aspect of the project showed the organisation or one of the key stakeholders in a negative light and what the impact might be, given the power of the stakeholders. Theoretically, the University was the least powerful stakeholder in the sense that any negative outcome that reflected badly on the organisation could result in a reduction in commissioning from Trusts and, increasingly, from students as self-funders. Given the multi-stakeholder input, I also needed to consider how any tensions or conflicting results would be managed.

Brannick and Coughlan (2007) suggest that the insider–researcher should demonstrate political astuteness in the context of the relative power and interests of each of the key stakeholders—directly and indirectly involved in or potentially affected by research. The potential to take business elsewhere was an on-going concern. I decided to take the stance that the key objective of the research was the enhancement of the student experience and that this objective should be re-enforced to all stakeholders. The important thing was to ensure that all stakeholders felt that they were listened to and that they, in turn, should respect the concerns of other stakeholders.

I was also well aware that I might not be popular if, as a result of the project, negative issues relating to the University, academic or service staff arose and were made public. Therefore I had to think about ways of turning what might be construed as negative into something positive. From the University academic and service staff perspective, this could be seen in the context of organisational learning and agreeing actions necessary to address and improve the issues—and making this public, along the lines of ‘you said; we did’. I decided that this would be my stance with the University, should the situation arise.

3.9 Issues of rigour

There is general agreement in the literature that the criteria for quality that are applied to positivist studies cannot be directly applied to interpretative studies. In the literature there is evidence of more than one way of thinking about quality in interpretative work. On the one hand some researchers use the same terminology as is used in positivist research but define and interpret it differently. For example, Janesick (2003: 69) discusses how validity in the positivist arena has ‘a set of microdefinitions’, whereas validity in interpretative work relates to description and explanation and whether the explanation fits the description. Holloway and Wheeler describe a similar approach in relation to rigour, reliability, validity, generalisability and objectivity (Holloway and Wheeler, 2010). An alternative approach is the use of interpretative-specific terminology and criteria as espoused by Lincoln and Guba (1985). They use the overarching term of ‘trustworthiness’, which they state is simply about the researcher being able to persuade the audience that the findings of an inquiry are worth paying attention to (Lincoln and Guba, 1985: 290). Trustworthiness criteria are listed below, along with the techniques that can be used to assess quality and to establish trustworthiness.

Table 8: Summary of techniques for establishing trustworthiness

Criterion Area	Technique
Credibility	Activities in the field that increase the probability of high credibility: <ul style="list-style-type: none"> • Prolonged engagement • Persistent observation • Triangulation (sources, methods, investigators) • Peer debriefing • Negative case analysis • Referential adequacy • Member checks (in-process and terminal)
Transferability	Thick description
Dependability	The dependability audit, including the audit trail
Confirmability	The confirmability audit, including the audit trail
All of the above	The reflexive journal

Source: Lincoln and Guba (1985: 328)

In the student experience line of enquiry, credibility would be achieved through triangulation, member checking and transferability through thick descriptions from the focus group findings. Transparency throughout all stages of the research process I hoped would enable the criteria for dependability and confirmability to be met. The chapters in the report that focus on project implementation, analysis and discussion chapters would demonstrate on-going evidence of reflexivity.

Quality and AR

From an AR perspective, McAteer (2013) argues that terms such as validity may at first seem appropriate criteria for assessment of quality, but in AR terms these may be conceptually incongruent. She questions the whole concept of objectivity in the context of AR with its focus on collaboration, co-operation and insider research (McAteer, 2013: 112). There have been numerous debates on appropriate quality measures for AR and there are a number of different models; for example, McAteer cites Dana's 2009 quality indicators model. This consists of five headings that the action researcher should consider and then demonstrate how these have been met in their work.

AR quality criteria

- Context of study
- Wonderings and purpose
- Principal research design (data collection and data analysis)
- Principal researcher learning
- Implications for practice.

(Dana, 2009, cited in McAteer, 2013: 113)

In relation to the stakeholder–curriculum line of inquiry, the project report up to this point has addressed issues around context, purpose and research design. Researcher learning and implications for practice will be addressed in later chapters of this report.

3.10 Concluding comments

This chapter has described the process of aligning my research question to the relevant research approach through consideration of a range of possible approaches located primarily in the interpretative and critical theory paradigms. Consideration has also been given to the mixed methods paradigm. The rationale for adopting a qualitative approach for the student experience line of enquiry and an AR approach for the stakeholder–curriculum line of enquiry have been discussed. Core aspects of the research process have been explored and then applied to each line of enquiry. Critical consideration has been given to issues of reflexivity, ethics, rigour, the status of the research participants and my role as an insider–researcher. At the same time the role and status of the research participants in terms of the collaborative relationships and relative power relationships were explored. The next two chapters will take an integrated approach to the implementation and findings for each line of enquiry, commencing with the stakeholder–curriculum line of enquiry.

Chapter 4 Project Implementation and Findings: Stakeholder–curriculum line of enquiry


4.0 Introduction

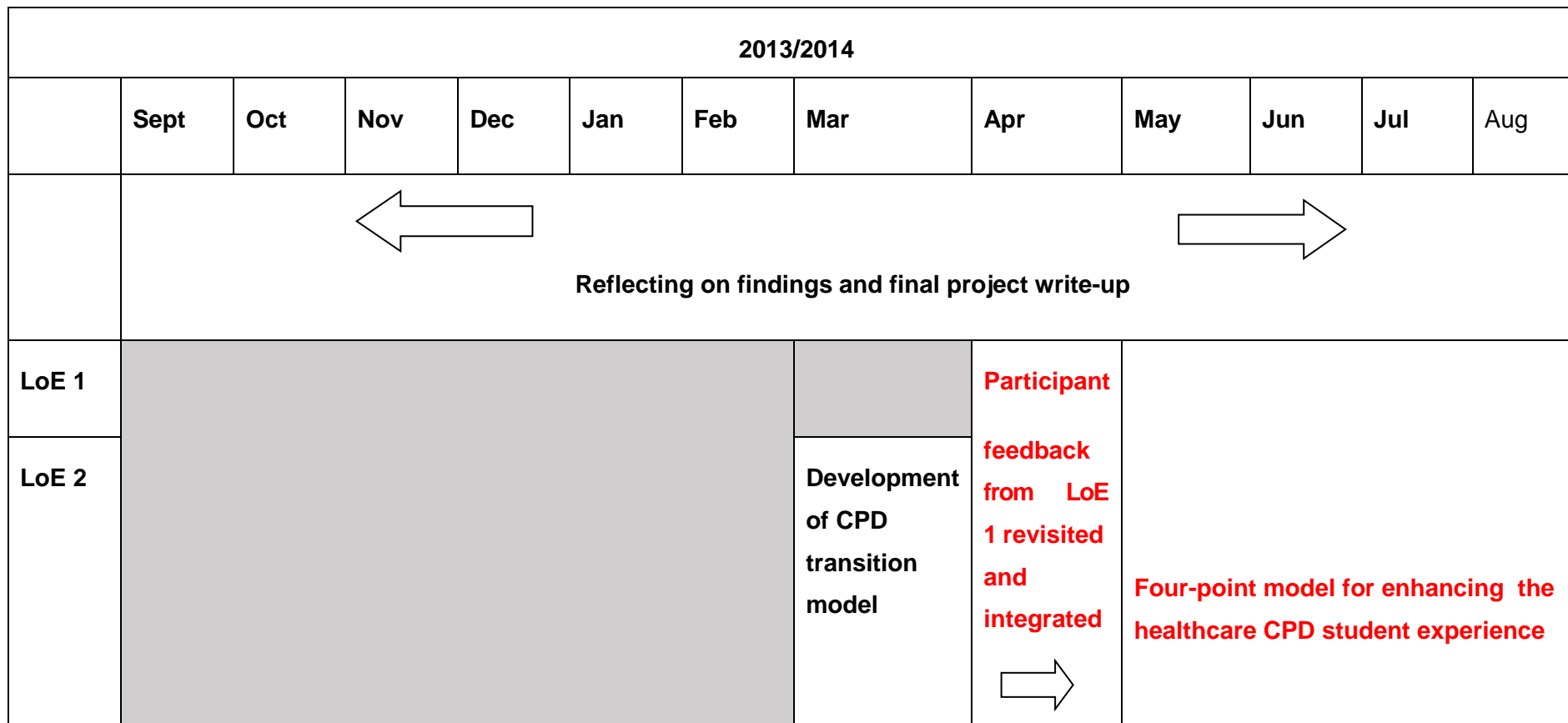
This chapter and the next focus on the implementation and analysis of both lines of enquiry: the stakeholder–curriculum and the student experience. The former is discussed in this chapter and the latter in the next. I had planned that the student experience element of the project would be implemented first, followed by and hopefully informing the stakeholder–curriculum line of enquiry. In the event it was the stakeholder–curriculum that was started first, influenced by factors such as the timing of workplace meetings, the operation of a particular module when access to students was required and other workplace events. One of the benefits of approaching the project in this way was the opportunity to triangulate findings from the student-stakeholder group with those from the student experience line of enquiry.

There were times during implementation phase where both lines of enquiry were being worked on simultaneously, but where the focus would be on one line rather than the other. For the purpose of this report, however, they will be treated separately. The diagrams that follow provide an overview and timeline for the project and the lines of enquiry.

2010/11												
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
LoE 1		Data collection: Professional conversations							Data analysis		CDS 1 st draft	
LoE 2												

2011/12												
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
LoE 1								Pilot CDS			Interview and analysis of feedback from pilot	
LoE 2	CPD student questionnaire development	Data collection									Questionnaire analysis	

2012/2013												
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
LoE 1	Final CPD incl. student profile data from LoE 2	Dissemination CPD Development of staff resource portfolio								Reflecting on findings and drafting project report		
LoE 2							CPD student FG	Analysis of FG transcript				



Key: LoE 1: Stakeholder–curriculum line of enquiry LoE 2: Student experience line of enquiry

Figure 5: Project timelines 2010–2014: Stakeholder–Curriculum Line of Enquiry

4.1 Developing a strategy for healthcare CPD provision: An action research approach

What follows is an integrated approach to the project activity and project findings elements of the stakeholder–curriculum line of enquiry. I have discussed both what was originally planned to take place (this was reflected in my ethics committee submission and subsequent approval) and what actually took place, justifying where appropriate the changes to the original plan. The format for this section is as follows: problem identification; planning; implementation; evaluation and reflection for each cycle of activity.

4.2 Action Cycle 1

Developing the strategy

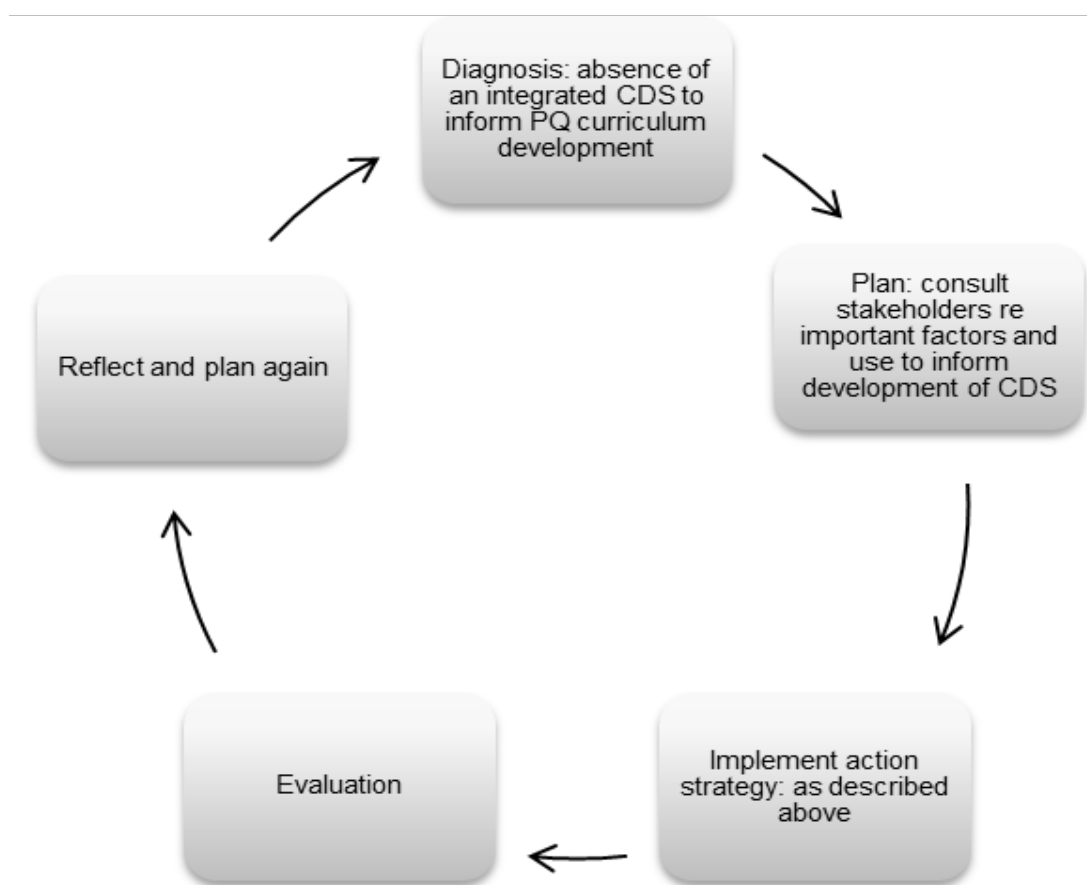


Figure 6: Action Cycle 1: Diagnosis

Absence of an integrated Curriculum Development Strategy (CDS) to inform healthcare CPD curriculum development

In this first cycle the diagnosis phase essentially took place over an extended period starting in 2007, when a significant part of my role involved working to establish a more

integrated perspective on healthcare CPD that highlighted the problems and ended with needing to answer the two key research questions. Diagnosis of the 'problem' was reasonably clear—the absence of an integrated CDS developed by key stakeholders that could be used by academics to inform healthcare CPD curriculum development activities. The core problem was that, despite the existence of a strategy for post-qualifying healthcare CPD, academic staff were either unaware of it or ignored it. As such there appeared to be no coherent approach to curriculum development activities, which were being developed on an ad hoc basis. If healthcare CPD provision was meeting the needs of key stakeholders, I argued that this was by chance rather than by design.

Planning

Action Point: Consult key stakeholders regarding important factors which they feel should be taken into account and use this feedback to inform the development of a CDS.

Initially I had planned to collect data from a broad range of stakeholders, including healthcare CPD academics, healthcare CPD academic staff, the School executive and senior academic staff: Associate Deans; Head of Institute of Nursing and Midwifery; Curriculum Leaders; Academic Group Chairs; senior School administrators; Commissioning Leads; NHSL. Data collection methods identified were: questionnaires, focus groups and document analysis of relevant SHA, University and School strategy documents and minutes of meetings.

Reviewing and reflecting on these proposals in the lead up to the implementation phase, it became clear that, if I carried out the project in the way that I had envisaged with the range of data collection methods proposed, this line of enquiry was likely to be large, unwieldy, time-consuming and probably unmanageable. I felt I needed a tighter, more coherent focus. Key stakeholders were identified as discussed in Chapter 3. In terms of the data collection method, I anticipated that most stakeholders would be consulted at pre-existing events or meetings rather than gathering participants together specifically for research study purposes. The discussions that took place with each group were conceptualised as a series of professional conversations rather than focus groups. All participants in all forums were informed about the purpose of the study.

Participants, data collection methods or sources of evidence	
Setting the strategy for PQ CPD education provision: An AR approach	
Participants/stakeholders	Data collection method/source of evidence
Healthcare CPD students	Professional conversation during the module
Academic staff: healthcare CPD teachers	Professional conversation during a professional forum meeting
Trust Commissioning Leads, Healthcare CPD Curriculum Leaders, Academic Group Chairs, senior School administrators	Professional conversation and agenda item during workforce planning conference. Post-qualifying Steering Group meetings
Strategic Health Authority: NHS London representative	Professional conversation through direct communication

As part of my role as DoP I had planned an ‘away day’ with a focus on workforce development planning for nursing and midwifery CPD provision. Key staff involved in CPD healthcare education at Middlesex and from partner Trusts were invited to attend. It seemed to me to be a good opportunity to use the ‘away day’ to canvas opinion from a range of stakeholders with a view to them becoming co-collaborators and to initiate the first AR cycle.

The purpose of the ‘away day’ was four-fold:

- To ensure that the University produced a Commissioning Guide that accurately reflected the Trust’s requirement in respect of education provision to support workforce development objectives
- To build on existing positive partnerships and to develop new partnerships
- To ensure that Trusts were aware of each other’s commissioning requirements in order to minimise the risk of non-availability of provision as a result of low commissioning numbers
- To produce a joint action plan to guide 2011/12 commissioning work.

Implementation

At the ‘away day’ I gave a presentation that included a discussion of the purpose of the project, the ‘issue/problem’, the AR nature of the project and my expectations and perceptions of stakeholders as co-collaborators. The first of the professional conversations took place and data from group discussion were collected in note form. I

aimed to repeat the process with the two other stakeholder groups—students and healthcare academics. The conference was deemed a success and achieved its objectives. An extensive action plan was produced, with a key action to ‘revise PQ/PR strategy in light of comments and feedback’, with a timescale of October 2010 to April 2011.

The action was implemented as planned. The student-stakeholder professional conversation group took place in February 2011. This particular group (Practice Teacher module students) was chosen because members were enrolled on a postgraduate Level 7 module and were likely to have had a significant amount of exposure to CPD provision at undergraduate level, either in a stand-alone CPD module or as part of a longer CPD programme such as an Advanced Diploma or an undergraduate degree and, as such, would have sufficient experience on which to reflect and to be able to comment knowledgeably on CPD students’ needs and requirements for healthcare CPD education and training. The academic staff healthcare stakeholder professional conversation took place in March 2011. Both groups, students and academics, were given the opportunity to discuss and to comment on the same presentation given at the ‘away day’ and to suggest amendments, deletions and additions.

The School Post-qualifying Steering Group (PQSG), comprising healthcare CPD representatives from the University (service and academic) and Trust Commissioning Leads (and chaired by me), was used as a reference group to confirm that views were accurately represented on the basis that a significant number of members of this group had also attended the ‘away day’. The members were largely in agreement with the way in which their views were represented and, following this agreement, thematic analysis of data took place. Data from each of the professional conversations formed Dataset 1.

Analysis of Dataset 1 involved moving through stages of reading, re-reading and subsequent immersion in the data, colour coding and labelling of stakeholder feedback statements. Feedback statements were then categorised. Finally, categories were collapsed into themes. This exercise was done twice, a month apart, to test whether on second review the categories were located under the same themes as on the first occasion. Some minor modifications were made the second time, but essentially the overarching themes remained unchanged.

Fifteen categories were finally identified. These were:

- 1 Professional applicability, practice-related, Trust/service objectives
- 2 Finances/ resources: student, Trust, NHSL, HEI
- 3 Nature of provision: design, delivery, facilities
- 4 Participants/audience
- 5 Quality and experience of teaching staff
- 6 Marketing of staff expertise and experience
- 7 Quality monitoring, assurance and enhancement
- 8 Marketing and communication
- 9 Academic and professional progression and achievement/employability
- 10 Portfolio of offer
- 11 Commissioning, compliance and monitoring
- 12 Quality of provision
- 13 Partnership
- 14 The student experience
- 15 HEI requirements.

The process of moving from categories to themes was useful in enabling me to conceptualise what stakeholders perceived to constitute the overarching and core aspects of curriculum development in the context of healthcare CPD. Six themes were identified, with Categories 10, 11 and 15 appearing in more than one theme.



Figure 7: Stakeholder–curriculum themes and associated categories

However, it was the categories rather than the themes that formed the core of the first attempt to produce a document for staff. Further refinement of categories resulted in Categories 6 and 8, and Categories 7 and 12 being merged, resulting in a final list of 13 categories.

Dataset 1: Professional conversations with key stakeholder groups and the Core Healthcare Principles Document

Analysis of Dataset 1 led to the development of a Core Principles Document which, in turn, became the basis of the first draft of the strategy.

The Principles Document and the first draft of the Strategy Document were fed back to PQSG in June and July 2011. These two occasions when member checking took place represented, I believe, evidence of the credibility of the study, but a drawback and limitation was the fact that PQSG included neither students nor SHA representation and, as such, I missed the opportunity to confirm the accuracy of their input. However, as the SHA data collection was via e-mail I was able to use elements of this verbatim in the analysis phase.

Following completion of the 'Principles' document and based on feedback from my professional consultant (Appendix 3), a second and third draft of the Strategy Document were produced. These included a context paper and a template for curriculum teams to use when developing and designing CPD provision. An excerpt from the context paper is included below:

Whilst a strategy of itself can be useful in providing an indication of the direction in which an organisation wishes proceed, there is the risk that it is read and then shelved, rather than being a live document which is actively used to inform practice. For this reason the themes and categories have been used as the basis for the production of a curriculum development form for use by healthcare CPPD academic staff when developing new or reviewing existing provision. The form is designed also to be used by key School Committees—Academic Planning and Validations and Approval to assess the extent to which the provision reflects the strategic direction in relation to healthcare CPD provision and meets the needs of key stakeholders.

Draft 3 was sent to the Chair of the School Academic Planning Committee, who commented that what was missing was a set of guidelines for use by staff and by scrutiny committees who might be in receipt of the completed curriculum development documentation. An excerpt from Version 4(i) follows, written to take this feedback into account:

Guidelines for all staff involved in the development, delivery and quality monitoring of post-qualifying/postgraduate health and social care continuing professional development provision

These guidelines aim to:

- Provide guidance for PQ/PG staff engaged in the PQ/PG health and social care CPPD curriculum development work.
- Provide criteria which can be used by the relevant HSSc Committees to evaluate new and reviewed proposals.
- Provide evidence to funders, commissioners, purchasers and other key stakeholders that Middlesex/HSSc PQ/PG healthcare CPPD provision is based on a strategic model which reflects the needs of key stakeholders.
- Ensure that provision is sustainable, provides value for money and is of the highest quality.

Advice for PQ/PG Health and Social Care CPPD Curriculum Development Teams

Please use these guidelines at the start of your curriculum development activities. They should be used to guide the full range of planning and development activities from initial planning including identification of the planning team, through curriculum design, document production and validation/approval.

It is expected that teams will include discussion or evidence of the use of the curriculum development principles in relevant V&R documentation. This could be the initial overview or critical review document produced in conjunction with either a new module or APPG form. Other evidence may be included in student programme handbooks or in staff CVs. School V&R scrutiny committees such as APC and V&A will use these as part of the assessment and scrutiny process.

CDTs should also provide guidance for scrutiny panels on where evidence can be found i.e. which document and what page numbers.

Advice for School scrutiny committees: Academic Planning Committee and Validations and Approvals Committee

Please use these guidelines as part of the scrutiny, assessment and approval process. It is expected that teams will include discussion or evidence of the use of the curriculum development principles in relevant V&R documentation. This could be the initial overview or critical review document produced in conjunction with either a new module or APPG form. Other evidence may be included in programme handbooks.

Version 4 (ii) was essentially a formatting exercise that resulted in the final draft of the strategy and guidelines dated April 2012.

Evaluation and reflection

Evaluation and reflection on this cycle related to two key areas: the extent of the achievement of Cycle 1 goals and the changing politico-economic context.

The production of the Curriculum Development Principles Document and subsequent versions of the Strategy Document were evidence of achievement of Cycle 1 goals and offered a partial solution to the 'problem' of the absence of a healthcare CPD strategy reflecting the requirements of its key stakeholders. In addition, the research activities—stakeholder consultation and analysis of responses—were vital to answering the research question: What factors need to be taken in account in the development and planning education provision for healthcare CPD students?

In relation to the achievement of goals, my assessment was generally positive in the sense that I achieved what I had set out to achieve. In particular, being an insider—researcher and relatively easy access to participants as a result of my position in the University contributed to this. It was relatively straightforward to gain access to the key stakeholders: students, academic staff, Trust/commissioning managers and the SHA, and obtaining data from them was also straightforward. Brannick and Coghlan (2007: 67) suggest that the higher the status of a researcher in an organisation, the easier it is to gain access to formal networks, although access to 'informal and grapevine' networks may be more difficult. In this case there was little difficulty in negotiating access. In my view this was also due to the positive relationships that I had built over many years and the commitment to CPD that I had demonstrated through my work as a teacher, team leader and clinical link. Coghlan and Brannick (2005: 64) also discuss the issue of role flexibility as an insider—researcher and this was clearly of benefit to me in Cycle 1, as can be seen at various points where I was able to move between my role of Chair (of PQSG or of the 'away day') and researcher in the same forum.

When the student-stakeholder group was discussing the factors that they felt should be reflected in a CDS they commented that, in their view, service users and carers formed a key stakeholder group missing from the process. As noted in Chapter 3, in the context of this project and in the context of healthcare CPD the direct service users are actually the students who interface with academic staff as users of the education service offered by the University. This mirrors the position of patients, clients and carers, who are direct

service users of the healthcare service and who interface with healthcare practitioners. That said, I was keenly aware of the prevailing discourse on the importance of service user and carer involvement in pre-registration nursing: recruitment, delivery and assessment. My view at this stage, however, was that service user and carer involvement in curriculum and programme design should feature at an operational rather than at a strategic level.

The challenge of implementing any healthcare education strategy and reasons for adopting a principles approach

My vision for the CDS was that it would be used to inform healthcare curriculum development for new provision and that which was due for review, rather than day-to-day, year-to-year curriculum revision. One of the drawbacks of this plan was that there are long intervals between one curriculum validation or review event and the next—typically five to six years. A review of the forthcoming validation and review cycle for healthcare CPD provision during 2011/2012 revealed that there would be few opportunities to use the CDS regularly and, even when used, this was likely to be on a one-off basis for a particular curriculum development team.

This finding shed light on one of the challenges of implementing previous strategies. Not only were previous strategies devised in a top-down manner; there was little reason for a team to consult a strategy more than possibly once every two to three years, at most. If a team was only involved in validation and review activity on a five to six year cycle, the context in which the strategy was developed would probably have changed between one validation and another, possibly making it appear irrelevant; indeed, the curriculum team itself may have changed. This was the context for this project, taking place during a period of politico-economic, health and education policy change.

I made the decision at this point to change to a principles approach that could be used to guide curriculum planning and development in a more generic way, so that the principles could be used to support new curriculum development and curriculum modification, and change on an on-going basis, not simply to support validation and review activity. This would increase the chances of academic staff engaging with the principles on a more regular basis.

Findings in the context of the CPD literature

In Chapter 2 I discussed the key themes in the CPD literature and, having completed the first cycle of research activity, I reviewed the Phase 1 findings in the light of the literature.

Curriculum Principles 1 and 2 align with the practice impact elements discussed in the literature. Trust and SHA stakeholders are in agreement that provision should result in change/improvement in practice and contribute to service/Trust objectives, so the challenge for CPD curriculum planners is to demonstrate to stakeholders that, in planning the curriculum, they are aware of and use teaching and learning strategies, which are more likely to result in practice change and organisational development and achievement of objectives.

The HE academic stakeholders' group feedback includes online distance learning and work-based learning as important teaching and learning strategies for CPD provision, but it is the CPD students who discuss the importance of tutor support. However, this is not in the context of online distance learning but as a key factor in decisions on where to study. So, whilst tutor support is recognised as being an important element in CPD curriculum planning, this was not mentioned in the context of online learning in the way that does Southernwood, for example, who discusses distance learning using web-based online material combined with tutor facilitation (Southernwood, 2008). What is also missing from the feedback is recognition that practice change is not solely the result of students accessing formal CPD. Whilst the stakeholders emphasise the importance of partnership (Principle 7) in curriculum development, there was no indication that stakeholders recognise the importance of a positive workplace culture as a key factor that needs to be in place alongside CPD education in order to facilitate practice change (Santos, 2012; Gould et al., 2007).

Tame (2009) discusses personal and professional changes resulting from the completion of CPD and student stakeholders. In this study this indicates that CPD provision should link to career development. Interestingly, students suggest that what is important for Trust/commissioners is that CPD should contribute to inter-professional progression and staff retention and, indeed, the Trust/commissioner group supported their view that it should support career development and enhance employability.

Feedback from stakeholders indicates the importance of a carefully thought through curriculum design that recognises the importance of study days and enables these to contribute to formal credited study, with the possibility of leading to formal academic awards. None of the stakeholders mentions the role of the University in recognising the contribution of informal learning along the lines discussed by Banning and Stafford (2008) or Gould et al. (2007), although this is a key aspect of the University's work.

Principles 5 and 6 both relate to enhancing the student experience and were developed in response to feedback from all stakeholders (including myself): phrases such as: work/life balance, short, on university site/away from work (my input) were used. Trust members and commissioners focussed on the slightly different angle of the student experience: good location for facilities; travel; discounts; pastoral care, support and equality. The student-stakeholder group discussed the need for provision to be short, realistic in terms of hours needed for study, awareness of non-contact time and module learning time and the opportunity to 'step on' and 'step off', but still collect credits. The negative elements associated with being on CPD programmes in terms of combining domestic commitments with work and study was not a major feature of the stakeholder feedback group, in contrast to the studies published by Cooley (2008), Gould et al. (2007) and Schweitzer and Krassa (2010).

Principle 5 relates specifically to teaching and learning strategies, as discussed above, in addition to University recognition of the need for diversity in relation to the main University student body. I would suggest that in fact Principle 6 should actually come before 5, on the basis that 6 sets the scene by describing the broad CPD student experience and 5 encourages an approach to curriculum planning and design that addresses learning styles, having first taken account of context in which CPD takes place for healthcare CPD students.

Not surprisingly, value for money was a key feature of the SHA stakeholder feedback:

'Good value for money, not just the overt cost, but including the cost of the individuals' time away from patients', and 'return on investment.'

The SHA stakeholders also comment on the need for CPD to be:

The right amount for the right people delivered at the right time of year.

'Amount', in their view, is the:

identification of what is needed to make the staff member competent/excellent and can be measured in academic credit, level of study, hours, simulation vs clinical delivery whether delivered by academic staff or supervised in the workplace.

Being competent or excellent suggests that the SHA is concerned with impact. In addition, SHA stakeholders' feedback indicates the requirement for a degree of flexibility and a focus away from 'one size fits all'. By contrast, Trust/commissioner stakeholders, HEI academics and students all discuss the requirement for provision to be short—perhaps for different reasons. In the terms discussed by the SHA above, for Trust/commissioners the costs and for CPD students the requirement for CPD to be short or part-time where

possible are likely to be significant. Cost is also relevant in terms of having to self-fund or to study in their own time when employers are not prepared to offer study leave or fund CPD studies. Lack of funding and study time is a key area in the literature associated with limited access (Schweitzer and Krassa, 2010; Santos, 2012). By designing short, 'step on, step off' CPD provision, HEI academics are helping to remove or at least reduce the barriers.

Quality and marketing are two elements featured in the Principles Document in response to stakeholder feedback. Quality indicators important to stakeholders are: credibility, standards of qualifications and being at the forefront of innovation of provision that is quality assured. None of the stakeholders discusses quality in terms of impact on practice or organisational change, although the SHA does refer to the need for the HEI to 'balance educational excellence with the service outcomes required by commissioners'. It is not evident from this feedback how stakeholders expect HEI to plan provision to demonstrate quality, although HEI academics themselves indicate that, for them, proven expertise is an important facet of CPD provision.

The changing politico-economic context of healthcare and health care education

As discussed in Chapter 1, HEI healthcare CPD provision was taking place in the context of increasing marketisation and an increasingly free market approach characterised by increased competition between HEIs. My overriding concern at that time was the uncertainty and rising concern among health and education colleagues, myself included, about how the Health and Social Care Bill and the Education Bill, having received Royal Assent, would impact on the level of funds available to Trusts to commission education and training for their staff. Similarly, within the HE context, the proposed introduction of higher tuition fees and the need for spending cuts in the context of the Government's deficit reduction programme meant that the University itself had to implement a significant restructure and give staff the opportunity to apply for voluntary redundancy. It was difficult to predict how this was going to affect healthcare academics but, in my view, it placed even more pressure on us to demonstrate to funders and commissioners that, despite these changes and uncertainties, we continued to offer a high quality product worth commissioning. It was important for Middlesex University (and its competitor HEIs) to retain or even increase its market share and the associated income stream.

Marketing of CPD featured in the feedback of three out of four stakeholders. For Trust members and commissioners, this was 'messages re: existing provision "out there"'. For HEI academics, the focus was on the need for academics to market themselves (and their

proven expertise). For the SHA, CPD provision should be 'clearly communicated and marketed so that Trusts know what they are commissioning and the outcomes they can expect'.

Although there is little written in the CPD literature that relates directly to marketing, it is possible to link this to the concept of value. Three aspects of value were discussed in Chapter 2 based on the work of McClung and Werner (2008) and Swanson (2009): an understanding (by the university) of what constitutes value to the stakeholder; the degree to which stakeholders perceive that a university provides value; and the need for a university to invest resource in educating stakeholders about the value that a university generates.

The way in which the University's CPD provision is marketed and the marketing message being sold to stakeholders provides an ideal opportunity to demonstrate to those stakeholders that the University understands what is important to them. I would even argue that the stakeholder consultation exercise in itself may be viewed as such a mechanism. Effective marketing of our CPD also provides the University with an opportunity to generate a value message to stakeholders, which in turn may positively impact on the stakeholder perceptions of HEI value in relation to CPD provision. The challenge, of course, is that different stakeholders may have different views on what constitutes value.

The concept of stakeholder value in this context is crucial. Perceptions of the value that a University generates and how this articulates with stakeholder values might be significant in determining stakeholder commissioning behaviour.



Figure 8: Stakeholder value model applied to healthcare CPD

There are three messages that could apply to the marketing of healthcare CPD and result in enhanced stakeholder perceptions of University value positively impacting on commissioning behaviour. First is a marketing message explicitly demonstrating the University's *understanding* of healthcare CPD requirements based on stakeholder consultation. The second is a message demonstrating that the University's healthcare

CPD curriculum *design and delivery* reflects stakeholders' expressed needs. Last is a message demonstrating that *outcomes* following completion of healthcare CPD at the University meet stakeholder requirements and expectations. These messages may be supplemented by an overarching marketing approach, which was clearly reflected in the stakeholder consultation aimed at ensuring that information about the University healthcare CPD offer is clear, informative and easily accessible to Trusts/commissioners and healthcare CPD students.

Opportunities for testing

The SHA/Trust/HEI commissioning cycle for 2011/12 was completed by April 2011 and the provision would be delivered from September 2011. A review of what had been commissioned revealed that there was little required in the way of new provision. If there had been, it would have provided an ideal opportunity to pilot the curriculum strategy. However, based on the experience of previous years' commissioning activity I was aware that there was usually an opportunity to respond to in-year requests from Trust members and Commissioning Leads for the development of new provision based on underutilisation of commissioned places for that year. My plan for Cycle 2 was to 'test' the use of the draft CDS with a new module that had been requested in-year and due to be delivered in 2011/12.

It is also worth noting that the second line of enquiry commenced in September 2011, thus I was sometimes working on both lines and at other times focussing specifically on one or the other.

4.3 Action Cycle 2

Testing the Principles Document in practice

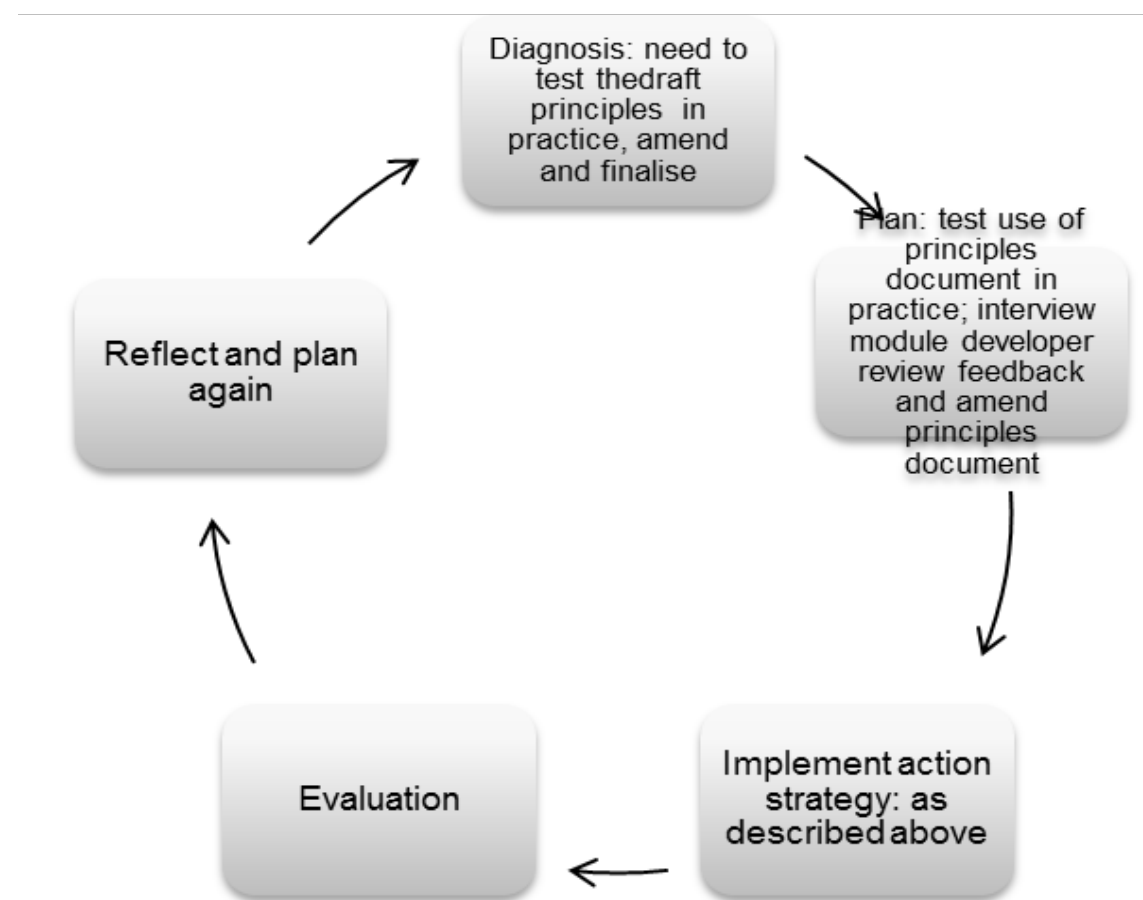


Figure 9: Action Cycle 2: Diagnosis, planning and implementation

In AR terms, the 'problem' was the need to test use of the draft Curriculum Principles Document (CPrD) and Staff Guide in practice, in order to amend and produce a final version. The plan was to test and then to amend CPrD on basis of feedback from the curriculum developer. The opportunity arose in April 2012. I talked through the CPrD with module developer, who was new to the University the previous September and new to teaching, although a very experienced practitioner. I asked her whether she would be willing to use the draft CPrD in the development of the new module and, following completion of module planning and subsequent submission to the School Validations and Approval Committee for scrutiny and validation, whether she would be willing to be interviewed by me about her experience of using the CPrD and she agreed. I treated this as a sample case.

The issue of role duality was particularly significant during this cycle in the sense that I sometimes found that the line between worker and researcher was blurred. This was

specifically the case when the module developer submitted the module the School Validations and Approvals Committee for consideration. The particular challenge here was that I was also the Chair of the Committee and, in conjunction with the panel, was responsible for providing feedback to her and validating the module. It required some thought in terms of how to proceed with the meeting. I decided that the best approach would be to declare my interest as a researcher when we came to consider the proposal and to exempt myself from the scrutiny and decision-making process. Having completed the main business of the meeting, I switched from 'Chair' to 'researcher' and asked the Committee for its thoughts on the quality of the documentation submitted. The feedback is recorded in the minutes of the meeting.

I chose a semi-structured interview format, using the CPrD as my interview guide, on the basis that I wanted to obtain feedback on each element of the document from the perspective of its use in practice as well as on the structure, format and interpretation of the meaning of each section in the guidance. In terms of ethics, I provided 'Jane' (a pseudonym for the module developer) with a participant information sheet and obtained her written consent. Issues of anonymity and confidentiality were discussed, as was the mode of data recording. I assured Jane that no one other than me would have access to the audio recording. The interview took place in July 2012.

Analysis and subsequent actions

In order to analyse the data from the audio recording, I listened to the recording from beginning to end on two occasions to familiarise myself thoroughly with what was being said. Third and subsequent hearings were used to make notes and transcribe key sections of the interview, and together these

Dataset 2. Simple analysis of the transcript and notes was carried out and core themes and issues identified.

The interview started with me asking Jane how she came to be involved in PQ curriculum development. From the interview notes:

Jane replied that she is a RN, RM, SL Midwifery, principally pre-registration teaching but also some post-registration—usually practice focussed. **No curriculum development experience.** At Middlesex she was asked to lead the development of a new module. No experience of writing modules or developing curricula.

I felt that this was an important issue in the sense that Jane came with neither previous 'baggage' nor expectations based on previous experience of curriculum development of what a module should look like.

Throughout the process of transcript and notation analysis the benefits of the use of the document emerged. Jane discussed the impact that using the Principles Document had on module development. She talked about how the document was a valuable tool in the sense that it encouraged her to think in terms of context setting and rationale for the module development:

I love this document because it set the whole module in context... clarified throughout, the direction of the module and why it was being produced.

Helps to write a live document. Background to how it came about shows that the team have really thought about this and can feed into subsequent documents.

Like a mini-validation for our CPD. Really helpful. Filled in very well.

There is also evidence from the transcript of the positive impact of the use of the CPD on consulting and partnership working. Jane discussed how the use of the CPD encouraged her to consult with stakeholders to ensure that the module met their needs:

Made me think more broadly and about what Trusts. Making sure it fitted their needs.

Enabled me to consult which I would not have got from the LUN form.

The form prompted me to do this.

Very valuable.

For Jane there were also aspects of the CPrD that were confusing or lacked clarity. She provided useful suggestions on how the document might be improved. For example, there were areas where I had made assumptions about a potential user's existing knowledge and understanding. One of the first questions in the CPrD asks whether the Sustainability Toolkit was used in the development of the module. I had clearly made the assumption that all CPD teachers knew what this was.

Jane: Makes the assumption that everyone knows what the tool kit is, and they may not.

In another example, the CPrD suggests that the development team should 'consider whether the cost of provision is financially accessible and realistic, and represents value for money from the perspective of the purchaser or the commissioner'. From the interview notes:

Jane and VB also discussed our understanding of the word 'accessible' and whether this was the appropriate term in the context of funding. We agreed that accessibility and affordability are quite different. We agreed that 'affordable' was more appropriate.

During the interview there were several instances where professional or academic jargon was used and was felt by Jane not to be helpful. From the interview notes, Jane felt she

needed more detail to understand what was meant by 'academic or professional progression and achievement', and alternatives were discussed:

- VB So an example would be helpful?
- Jane: Would have been really helpful.
- VB: I am thinking of using the word 'employability'—so, 'academic development and employability'?
- Jane: Yes its 'academic or professional progression and achievement'.... I'm looking at it and now I'm understanding what you mean but at the time I was a bit 'OK...'

In another example, the CPrD requires development teams to consider how far their provision fits the model of 'discrete/linked study days, which can be delivered as stand-alone units, feeding into a module (available at Levels 6 and 7) which in turn contributes to an award'. This model had been well received at past validation and review events and I felt it was a useful way of assisting curriculum teams to conceptualise their curriculum planning and to consider how their provision might feed into longer programmes and reflected academic/HEI stakeholder consultation feedback. I explained this to Jane and asked if she understood the diagram in the CPrD.

From the interview notes:

Jane replied yes, but she had to have a conversation as she was not familiar with jargon. Suggested that 'unit' should be replaced by stand-alone study day. The same applied to the use of acronyms:

- Jane: Less jargon and more saying what you mean. There are the odd ones where I had to clarify a bit.

What was encouraging, however, was despite the lack of clarity in places the use of the CPD still promoted consultation:

All of these prompted me to start asking questions.

During the interview Jane noted how useful the CPrD could be for students if they were provided with information about how the CPrD was used to assist in module development:

It gives the students the background to what it is all about. Not in a long and detailed way, just in a way that says we have really thought about this.

I felt that an important point was being made here supporting the stakeholder value model. Not only would a short description of how the module came to be developed provide students with contextual background and a rationale for the module but, for commissioners and student self-funders, the use of the CPD could be a key aspect of our

marketing strategy. Jane's feedback supports the 'understanding' marketing message in the value model. Following this analysis I had several conversations with members of the marketing team about incorporating this message into our approach to marketing. A phrase such as, 'Our CPrD: Based on what **you** think is important', might be a powerful marketing message and act as an incentive to access information about our CPD and commission or purchase healthcare CPD modules or programmes.

In relation to structure and format, Jane comments on the use of closed questions, which I initially viewed as elementary 'error'. Using closed questions is frequently referred to in the research literature as a key shortcoming when in-depth response from respondents is required. Although the respondent is not completing the documentation as part of a research study, in the context of the CPrD the advantages and the shortcomings of the use of the closed question could still apply. Denscombe, for example, discusses how use of closed questions in research terms may be a frustrating experience that denies the respondent the opportunity to express their views fully and 'to supply answers which reflect the exact facts or true feeling on a topic' (Denscombe, 2003: 156).

Whilst not describing it as a frustrating experience, Jane discussed how the use of the closed question discouraged further discussion or consideration:

The questions did not encourage me to go any further. I just said 'yes it does represent value for money'.

What was interesting was my response to this:

The difficulty for me re the resourcing question was being aware of a degree of resistance to filling in the form so I wanted to make it easier for people by saying just say yes or no—but perhaps not very helpful.

My intention at the time was the antithesis of Denscombe's views on the use of closed questions as a frustrating experience; for me, the use of the closed question was envisaged differently—I wanted to make the whole business of form-filling an easy experience for curriculum teams. This was the second time that I had raised the issue of staff resistance to completing documentation, yet I had not realised this until I listened to, annotated and transcribed the recording. I have reflected on this below.

Jane also provided helpful feedback on the layout of the CPrD and suggested that the box format was not useful, and that all boxes could be removed as they were not needed.

In my view, one of the reasons why previous strategy documents have not been used as fully as they might have been is that they were not necessarily effectively disseminated nor

easy to locate when required. I was keen to discuss with Jane how she felt the CDS should be disseminated. From the interview notes:

VB asked Jane's opinion on how to get the CPrD 'out there'. Jane replied that a multi-pronged approach would be needed.

Jane Need to do several [approaches]. Definitely meetings so that it is in people's faces as well as on e-mail (but could be filtered).

VB discussed a third, more strategic approach and plans for a shared CPD resource folder:

Jane: That would be really helpful.

In the light of the analysis of Dataset 2, amendments to the CPrD were made in order to enhance comprehensibility and usability.

Dataset 2: Interview transcripts and notes after testing CPD, CPrD and Staff Guide

Feedback from Jane on the use of the CPrD in practice was hugely valuable in terms of structure, wording and interpretation of meaning of elements of the CPD and the identification of where and how this could be improved. A summary of all CPD changes in Cycles 1 and 2 (and beyond) may be found below.

Table 9: Summary of changes to the CPrD

Date	Version(s)	Feedback source	Change
Cycle 1			
Oct 2011	1	Key stakeholders in presentations and data collection process	N/A
Feb 2012	2 & 3	Professional supervisor	Clarify aims and objectives, add context setting segment. Formatting changes.
April 2012	4 (i, ii)	Chair School Academic Planning Committee	Guidelines for use of curriculum development document added. Formatting changes
Cycle 2			
Oct 2012	5	Jane, following testing of the CPD	Changes to curriculum development guidance to enhance comprehensibility. Final products: separate Curriculum Principles Document and Staff Guide.

Evaluation and reflection

As an insider–researcher engaged in a one-to-one interview, one of the issues that I was aware of from an early stage was the difference in experience and ‘position’ between Jane and I. Jane was a newish member of staff with considerable practice but relatively little teaching and curriculum development experience. In many ways I saw this as an advantage in that, as a new member of staff, Jane came with no Middlesex-associated baggage and would be a pair of fresh eyes. There is agreement in the literature about the impact that differences between the power status of the interviewee and the interviewer may have on the interview process and responses. Throughout the interview I tried my best to make Jane feel at ease. I emphasised the fact that it was really important for her to be candid in her responses and that her responses would provide insight into how the CPrD worked in practice, which would in turn potentially result in a better product. This could have been interpreted as undue pressure and probably was not helped by the fact that the interview was carried out in my office rather than in a neutral space.

Wilkinson and Kitzinger (2013) discuss four ways of managing the insider experience. Utilising experience is one approach whereby the researcher’s experience of being an insider is used at the data collection stage in ‘engendering trust...’ (Wilkinson and Kitzinger, 2013: 252). I would like to believe that Jane felt more trust than undue pressure. The importance of demonstrating credibility as a criterion for the rigour of a study has been discussed above. In this cycle, one of the main drawbacks to credibility was the fact that I was unable to return to the interviewee with the notes and transcript excerpts in order to member check, as Jane left the University.

Two full cycles of AR were completed and as a result I felt that I was able to answer the research question adequately. I now had a clear idea of what factors key stakeholders in CPD felt needed to be taken into account healthcare CPD planning and development. The next stage in the process for me was to work towards dissemination of findings and products resulting from the study.

‘Getting the word out’: Dissemination of the CPrD and Staff Guide

In terms of disseminating the CPrD, I reviewed the final section of the interview data to consider Jane’s views. She had suggested a multi-pronged approach including staff meetings. I considered that the staff meetings could be supplemented with additional dissemination approaches and decided the best approach would be to consult the University e-Learning team. A meeting with ‘Y’ from the team was helpful in terms of

providing me with a range of possible options, including: formatting the CDS as a .pdf and distributing by e-mail; constructing a wiki; and developing a webfolio using PebblePad.

I decided on PebblePad partly because the wiki is generally for use by multiple users who can add, modify and delete content. It usually requires a password in order to access the content and this in many ways seemed at odds with the University's recent move towards single-password access. Pebblepad, by contrast, can be accessed using a single URL and the content management is limited to the 'owner' of the portfolio. However, access may be given to others. Having chosen the webfolio, it was relatively easy to produce; a distinct advantage, moreover I acquired a new skill.

Dissemination took place in conjunction with the development of the webfolio. Feedback from one forum strongly supported the webfolio approach, but suggested that other documents needed by CPD teaching staff could be uploaded to the same site. The webfolio therefore expanded from being simply a repository for the CPrD and guide to a full CPD resource file, completed in November 2012. This was the third and unintended product of the project. Further presentations took place in December 2012 and in early 2013. Along with the project, the CPrD and Staff Guide was used in the development of a two new awards during 2013 which, by coincidence, involved staff from my cluster area.

The stakeholder–curriculum line of enquiry: insider researcher issues

In Chapter 3 I discussed the process by which I located myself within the project in the context of self as researcher and the 'system' using Coghlan and Brannick's (2005) model based on the researcher, the system and commitment to self-study in action. I concluded that in this project there was no commitment or intention to system self-study but, as an insider researcher, there was a firm commitment to reflective study of my own professional practice. In the same chapter I discussed the Herr and Anderson (2005) action research positionality continuum in an attempt to be clear about the nature of the relationship between myself as an insider researcher and the key stakeholders in the project. I concluded that in the context of this project I was an insider researcher working in collaboration with outsiders.

A further dimension of the insider role is that of the insider researcher/worker and the challenges of carrying out research within the organisation where one is employed. Coghlan and Brannick (2005) describe this as role duality and suggest that the insider researcher needs to consider issues such as role identity, role boundaries and the movement between researcher and worker. Working as a researcher in the organisation

where one is employed requires consideration of the potential for conflict, as the insider researcher/worker may be 'caught between the loyalty tugs, behavioural claims and identity dilemmas' (Coghlan and Brannick, 2005: 65).

The insider researcher/worker role was a key issue for me, requiring consideration of both lines of enquiry and, in particular, the stakeholder–curriculum element of the project. Being an insider researcher/worker was a distinct advantage in terms of gaining access to participants with whom I work or meet on a regular basis as part of my role as DoP. For this line of enquiry I used existing work-related forums to gather data rather than setting up specific meetings for this purpose. Data were gathered through a series of professional conversations. In many ways the boundary between researcher/worker was blurred in the sense that the issues being explored were those that were relevant and appropriate, and could easily have been discussed as part of my role as a DoP. Indeed, it was easy to see how (with the exception of the student group) this could form part of the agenda for any of the workplace meetings that took place regularly with stakeholders. As such it was possible that the stakeholders did not perceive me as having a researcher role at all—I was just doing my job. I managed the potential invisibility of the researcher role by being explicit and open about the project. I made it clear that the data from professional conversations which took place were being collected as part of a research project. For me, the bigger issue was that the data I collected from key stakeholders (with power) might uncover issues damaging to the organisation.

One of the professional conversations that came to inform the Curriculum Principles Document was with healthcare academics with whom I worked on a day-to-day basis, some of whom I had known for a long time. As such I needed to be aware of the risk of bias from my insider status that might have underpinned my interpretation of the data. The process of member checking went some way towards reducing possible bias.

In the second cycle of the stakeholder-curriculum line of inquiry I interviewed the healthcare academic who tested the Curriculum Principles Document. Elsewhere in this project I have discussed the challenges of being an insider researcher engaged in a one-to-one interview with a colleague with relatively little teaching and curriculum development experience. The issues of power relationships between the interviewer and interviewee were also discussed. It is possible that being an insider (senior) worker/researcher with a vested interest in the project could have impacted on this colleagues' responses, although a review of interview notes and transcript did not suggest that this took place. However it might have been more appropriate if a colleague with less vested interest than myself had conducted the interview.

The stakeholder–curriculum line of enquiry: Ethical issues

I did not perceive anonymity, confidentiality and informed consent as being problematic at the start of this line of enquiry, but Williamson et al. (2012) urge consideration of consent, anonymity and confidentiality at all stages of the AR project. What I did not consider at the outset was that the commissioning managers, who comprised one of the key stakeholder groups, knew that the student-stakeholder group which participated were on a postgraduate CPD module. As commissioning managers they would have been aware of how many places were commissioned on the module and they would have also signed off application forms, which in turn meant that the anonymity of the student-stakeholder participants was compromised. This was a potential problem that I did not fully address yet should have done. That said, in the context of informed consent the student group members were informed and aware of who the other research participants were, and were aware that commissioning managers would be viewing their contribution. Despite this they consented to participation. On reflection, I am not sure whether there was a need for anonymity at all if stakeholders were co-collaborators, with equal status as far as contribution to the research was concerned.

4.4 Summary

In this section I have described the development of a CPrD and Staff Guide through two cycles of AR, focussing on their diagnosis, implementation, reflection and planning phases. In the next section I will use the same approach taken in the first line of enquiry, that is, an integrated discussion on what I proposed to do and what changes took place at the implementation stage, followed by analysis of findings and discussion for the student experience line of enquiry.

Chapter 5 Project Implementation and Findings: Student experience line of enquiry

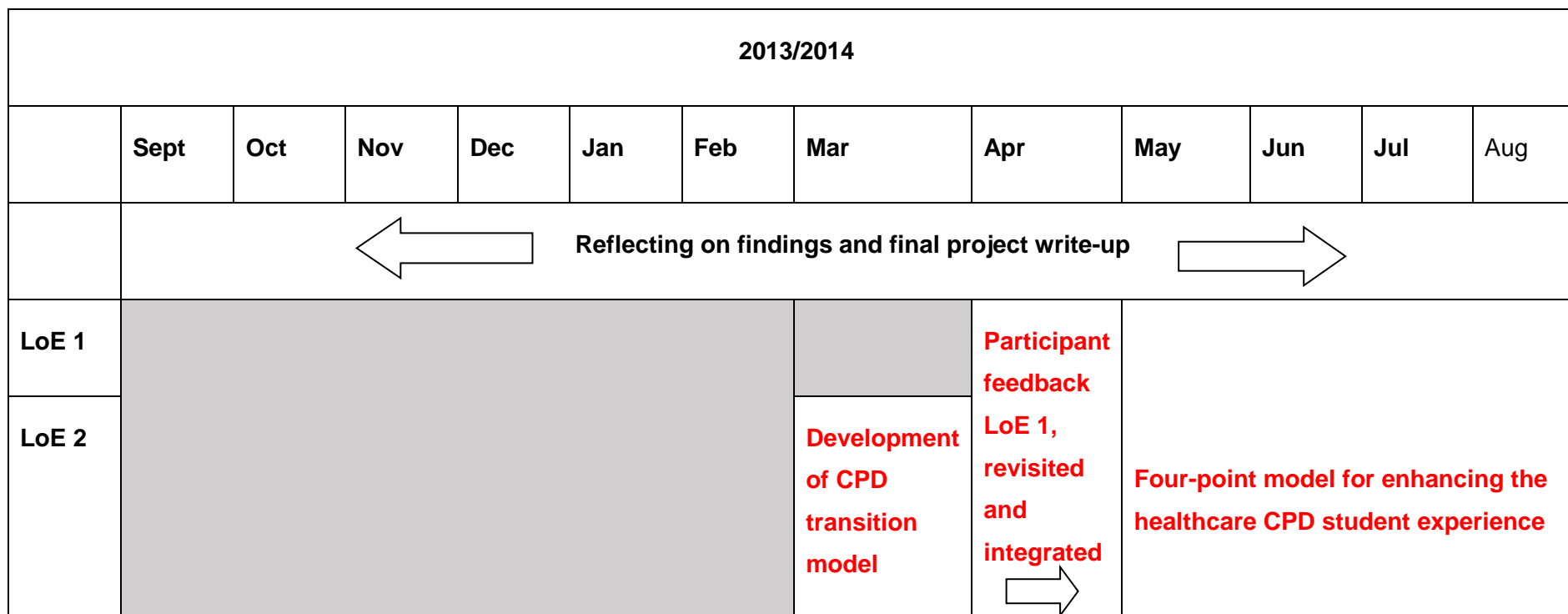
5.0 Introduction

This chapter focusses on the implementation and analysis the student experience line of enquiry. As discussed in Chapter 4, I had planned that the student experience element of the project would be implemented first, followed by and hopefully informing the stakeholder–curriculum line of enquiry. In the event, the student experience line of enquiry commenced approximately one year into the project. The following charts provide an overview and timeline for this line of enquiry. This chapter also focusses on triangulation of the results of the two lines of enquiry and the integration of findings leading to the development of the final product—a four-point model for enhancing the healthcare CPD student experience.

2010/11												
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
LoE 1		Data collection: professional conversations							Data analysis		CDS 1 st draft	
LoE 2												

2011/12												
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
LoE 1								Pilot CDS			Interview and analysis of feedback from pilot	
LoE 2	CPD student questionnaire development	Data collection									Questionnaire analysis	

2012/2013												
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
LoE 1	Final CPD incl. student profile data from LoE 2	Dissemination CPD Development of staff resource portfolio								Reflecting on findings and drafting project report		
LoE 2	<div>↑</div>						CPD student FG	Analysis of FG transcript				



Key:

LoE 1 Stakeholder–curriculum line of enquiry

LoE 2 Student experience line of enquiry

Figure 10: Project timelines 2010–2014: Student experience line of enquiry

This line of enquiry comprised two elements: a questionnaire and a focus group. Data collection for the questionnaire took place between October 2011 and April 2012 with analysis between May and July 2012. The CPD student focus group took place in April 2013. Ethics Committee approval was given on the basis of the intended research activity.

In a similar vein to the stakeholder–curriculum line of enquiry, at the start I reflected on whether the participants and methods planned were appropriate to the issues that I wished to explore. On revisiting the overarching ‘problem’ of student invisibility, representation and absence of voice, I began to think that the original plan to include academic staff, administrators and Middlesex University Student Union (MUSU) in the project at this stage was inappropriate. It seemed to me that if I were truly serious about wanting to discover more about the student experience for healthcare CPD students studying at Middlesex, in the first instance at least it should be the students themselves from whom data were collected, to ensure that as far as possible their voices were heard, their experiences in their own words shared, reflected on and disseminated. I felt it to be inappropriate and not in the spirit of my values to ask others about their perceptions of the student experience without first exploring this with students themselves. In fact, it was my belief that rather than talking other stakeholders should listen and reflect on findings. I should have compared and contrasted different stakeholder perspectives, but decided that this was not the main purpose of the study. This was about student voice.

I decided that the project should take a slightly different format to that which I had originally planned. The time needed to devise, pilot, administer and analyse the results of questionnaires for the administrative staff, interview the MUSU team and carry out a focus group with the associated thematic analysis of transcripts for both along with the student questionnaires was considerable and, in my view, well in excess of what was necessary to obtain the information needed to give me the answer to the research question.

I spent considerable time worrying about whether the fact that the project as planned differed from that which I proposed to implement in the context of the approval obtained by the Ethics Committee. In the end I rationalised that, as I was doing less rather than more, this would not require me to re-submit my proposal. The aim of the revised plan was to obtain a student-only perspective on the CPD student experience at Middlesex by administration of a questionnaire to a range of students taking healthcare CPD modules or programme, then to follow this up with a focus group in order to obtain more in-depth data on the student experience.

5.1 Healthcare CPD student experience: Questionnaire development and implementation

My starting point for questionnaire development was to use documents produced by the University Student Experience Group (SEG) and subsequent marketing material to provide insight into what the University perceived as being key aspects of the student experience. Ten elements were eventually identified and these were listed along with a short explanation for each element.

- **Engagement**—student engagement: this might include sharing your experiences, giving feedback, participating in surveys and Boards of Study, feeling as though you belong, feeling like a University student, wanting to engage.
- **Communications**—to and from the University at all levels.
- **Learning and teaching**—including quality of teaching, issues around assessment, issues around achievement (results), impact of teaching, academic staff support.
- **Support for learning**—this might include the work of the Learner Development Unit for example, the Student Office services, Data and Assessment services, induction, enrolment, academic staff support.
- **Learning resources**—library, information technology, e-learning.
- **The learning environment**—classrooms, study areas etc.
- **Support services (non-academic)**—counselling, welfare, money, finance, catering, student concessions, accommodation, childcare, disability support.
- **Student life**—Middlesex University Students Union involvement, social and extracurricular student activities and societies, bars and entertainment.
- **Sport**—competitive sport, exercise classes, gym membership.
- **Careers service**—careers advice, personal development planning, employability skills.

The ten elements were used to inform questionnaire development. The questionnaire was drafted and feedback was obtained from two critical friends, both of whom are experienced researchers, and redrafted in the light of this feedback. The final questionnaire required respondents to provide factual information based on demographics and opinions using a Likert scale, with the opportunity to add free text narrative in some sections. I proposed the use of percentages and numbers in the analysis. The use of 'simple counts' in line with Green and Thorogood (2009: 221) was to indicate how common were specific views. The final questionnaire was developed by September 2011 (Appendix 8). At the same time I started to consider issues of identification of and access to student groups. My role as an insider–researcher and as DoP with frequent contact with

CPD healthcare programme and module leaders was a distinct advantage in being able to identify both a purposive sample and who to contact to gain access to the potential participants. In order to gain feedback from as wide a range as possible (whilst being aware that this was not in any way a representative sample), I decided that the sample should include the following students: CPD students taking stand-alone modules at undergraduate and postgraduate studies at FHEQ Levels 6 and 7; and students taking longer awards at FHEQ Levels 6 and 7. I wrote to the relevant Directors of Programmes, Programme Leaders and Module Leaders requesting access. Table 10 shows the student groups and the programmes and modules accessed.

Table 10: Student groups participating in the student experience questionnaire

<ul style="list-style-type: none"> • Qualified social workers taking a 30-credit module preparing them to assess student social workers in practice. Students could be taking the module either as stand-alone or as part of a longer post-qualifying Social Work award.
<ul style="list-style-type: none"> • Qualified nurses taking the first core module of an undergraduate nursing top-up degree.
<ul style="list-style-type: none"> • Qualified nurses taking the 2nd and final core module of an undergraduate nursing top-up degree (dissertation).
<ul style="list-style-type: none"> • Qualified nurses, midwives or mental health nurses taking a 15-credit module to enable them to assess student nurses in practice. Students could be taking the module either as stand-alone or as part of a longer post-qualifying • Top-up degree in nursing, midwifery or mental health.
<ul style="list-style-type: none"> • Qualified nurses or midwives taking a 30-credit core module as part of a postgraduate degree in nursing or midwifery.

Green and Thorogood (2009: 128) suggest that a sampling strategy should be such that the maximum opportunity of producing enough data is achieved. In the final sample of this study, postgraduate stand-alone module representation was absent. My experience as a DoP and my involvement in the development and validation of undergraduate and postgraduate nursing programmes influenced my thinking at this point. In my view, many students who access healthcare provision at Masters level are likely to have accessed a stand-alone module at Level 7 prior to commencing the degree, usually to test whether they have the ability to study at postgraduate level. These students will have transferred the credits gained from the module into the degree using the University's accreditation of prior learning processes. On reflection this was a limitation of the study—that is, making the assumption about Level 7 single module experience rather than asking a specific

question related to this or continuing to seek permission from postgraduate module leaders to gain access to students on a stand-alone module.

One of my concerns at this point again was my role as an insider worker–researcher. Having worked at Middlesex University for a considerable length of time I was concerned that some of the students would be familiar with me from my role as a module leader and current role as a programme leader for the nursing top-up degree. I was not sure whether this would be problematic in terms of power relations and undue influence. I reasoned, however, that this was not likely to be the case as the questionnaire was anonymous. This was more likely to be an issue in the context of one-to-one interviews or to a lesser extent the focus groups.

Administration of the questionnaire and data collection took place between October 2011 and April 2012 and was relatively uneventful. In all cases I attended the start or the end of a module teaching session in order to explain the purpose of the study, to distribute the questionnaire, to answer any questions and to re-iterate that questionnaire completion was optional and anonymous.

5.2 Findings and discussion from the healthcare CPD student experience questionnaire

The questionnaire comprised two sections. The first was entitled 'Questions about your Experience as a Student on a Health or Social Care CPD Module/Programme', and the second 'Finally Some Questions about You....'. The first section comprised questions designed to elicit information from the respondents about their perceptions of being a healthcare CPD student studying in a HEI and of the HEI itself. In this section I focussed on 'counts' to give an indication of preference and inclination. Each question included a free text section, useful in providing some (limited) insight into the CPD student experience. The second section was designed to provide demographic information about the respondents. Although this was the end part of the questionnaire, findings from this section actually help to set the whole questionnaire in context in terms of demographic characteristics and so are reported first. Data from the questionnaire formed Dataset 3. Data analysis took place in July 2012.

What is important to re-iterate at this point is that although I used numbers and percentages to represent the findings, the sample was never intended to be representative and therefore was not statistically significant. The findings themselves

would not be generalisable; rather, they were context-specific. However, this does not preclude them from being applicable to similar settings.

5.3 Demographics—a snapshot from a purposive sample of health and social care CPD students

Table 11 shows the numbers of students in the purposeful sample. Where appropriate, student numbers on the undergraduate top-up degree programmes (nursing and mental health) were amalgamated to make a single undergraduate group.

Table 11: Student groups participating in the student experience questionnaire

<p>Qualified social workers taking a 30-credit module preparing them to assess student social workers in practice. Students could be taking the module either as stand-alone or as part of a longer post-qualifying Social Work award.</p> <p>Number of respondents: 18.</p>
<p>Qualified nurses taking the first core module of an undergraduate nursing top-up degree.</p> <p>Number of respondents: 12.</p>
<p>Qualified nurses taking the second and final core module of an undergraduate nursing top-up degree (dissertation).</p> <p>Number of respondents: 4.</p>
<p>Qualified nurses taking an undergraduate mental health top-up degree</p> <p>Number of respondents: 2.</p>
<p>Qualified nurses and midwives taking a 15-credit module to enable them to assess student nurses in practice.</p> <p>Number of respondents: 13.</p>
<p>Qualified nurses and midwives taking a 30-credit core module as part of a postgraduate degree in nursing or midwifery.</p> <p>Number of respondents: 8.</p>

Demographic findings

The analysis of responses to two questions related to past and present modules or programmes of study was of limited usefulness. Feedback served only to confirm the great breadth of modules that respondents had undertaken. These ranged from students taking their first module post-qualification through to students having completed multiple CPD modules either at undergraduate or postgraduate level, and either as stand-alone or as part of an undergraduate degree programme.

I presented the responses to the remainder of the student experience questions in percentages as well as absolute numbers to enable comparisons to be made between

student groups in percentage terms. I was aware that some of the percentages were based on very small numbers, so including the absolute numbers in addition to the percentage at least made the analysis more transparent. The analysis that follows is calculated on the basis of numbers who completed each question, not the number of students in the student group.

Age

In terms of age, the largest number of CPD students fell into the 30 to 39 age range and this was consistent across all student groups that participated in the questionnaire.

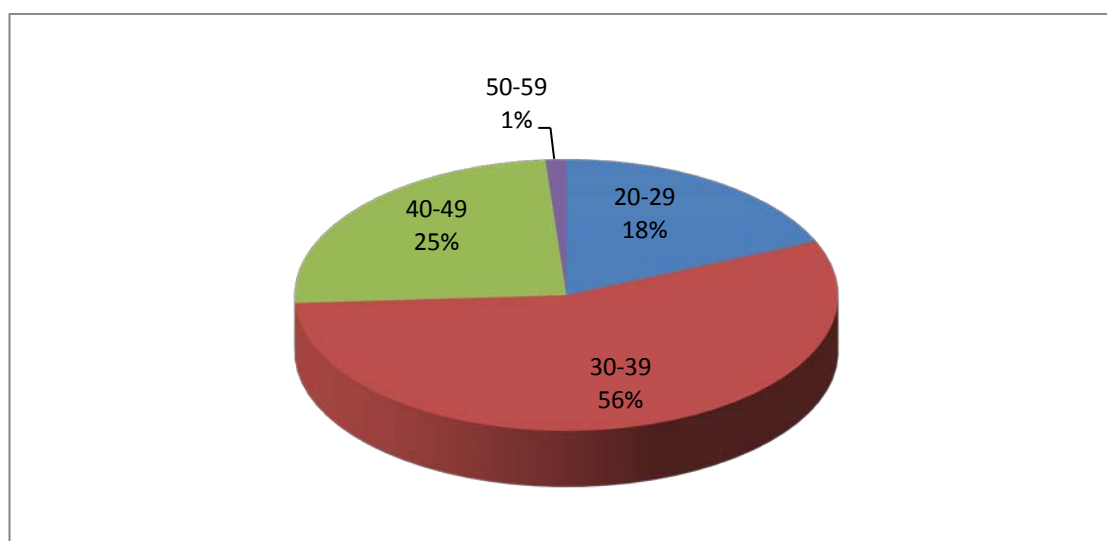


Figure 11: Ages of CPD students

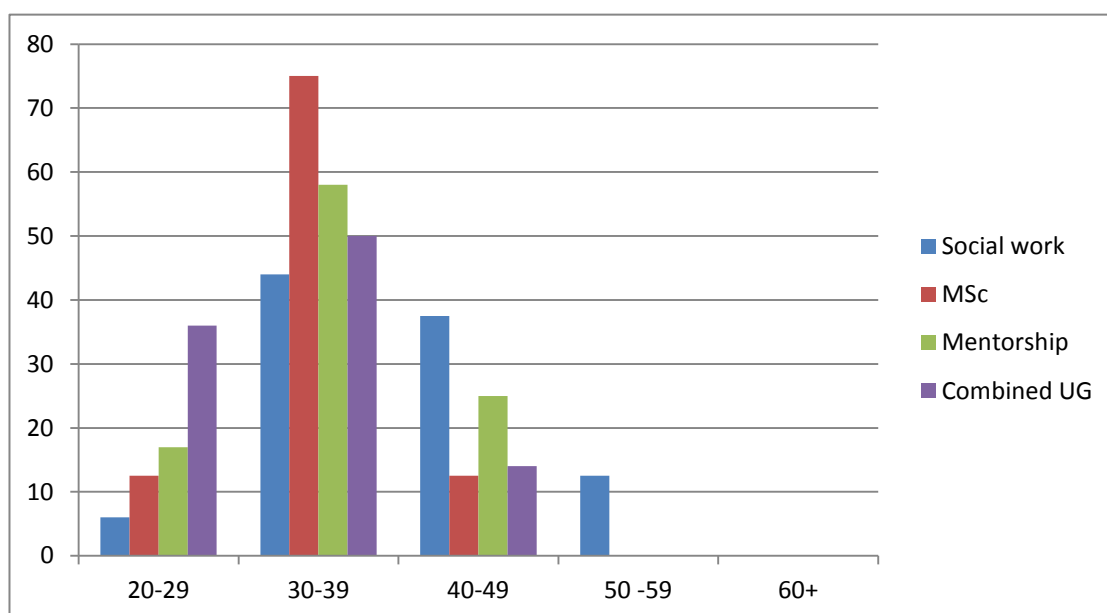


Figure 12: Age by study group (%)

In comparison, national statistics for 2010/11 indicate that approximately 53 per cent of undergraduate students fell in the under-20 age range. The groups with the highest numbers of students in the 30+ age range were taking postgraduate research, postgraduate taught or other undergraduate programmes, which could, of course, also include healthcare CPD provision (Universities UK, 2012). This information again helped to provide contextual background.

It is difficult to know if the findings from this question were representative of the CPD student body at large but, from my experience as a CPD teacher, in some cases accessing CPD studies is dependent on having a minimum number of years of experience in a related clinical setting, possibly increasing the age at which CPD studies are undertaken.

Years since qualification

The findings in this section were again unsurprising. The highest percentage of students who had been qualified for the least amount of time, 0–5 years, were in the two stand-alone CPD modules of practice assessor and mentorship. CPD students are likely to need to undertake modules such as these early in their careers, as most will be required to mentor and assess pre-registration students on practice placements.

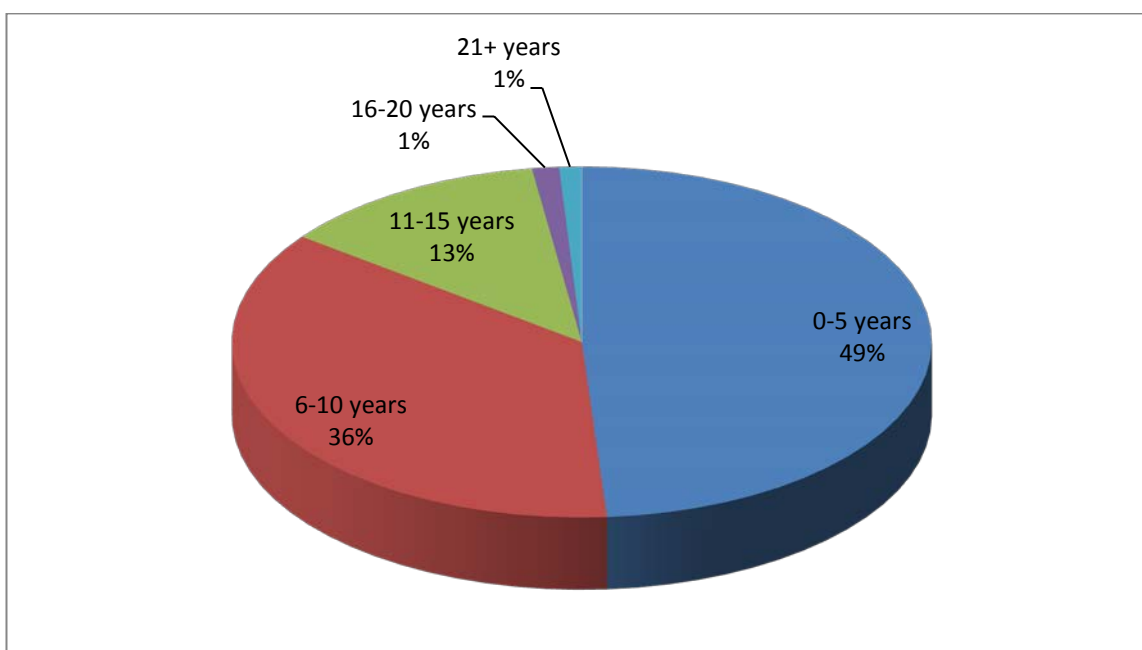


Figure 13: Years since qualification

It also made sense that students taking PG programmes had been qualified for longer. Taking this finding in conjunction with the age profile, although participants in the

questionnaire generally showed an older age profile, they seem to have undertaken CPD studies early in their post-qualification careers.

Findings from the demographics element of the questionnaire enabled me to start to assemble a profile of CPD students in this sample:

- Age generally: 30s and 40s
- Time qualified: 0–10 years.

There was a final question relating to funding in this section that, although not strictly demographic in nature, provided helpful but not unexpected confirmation on the composition of the student group. Findings from this question enabled me to add to the initial healthcare CPD student profile.

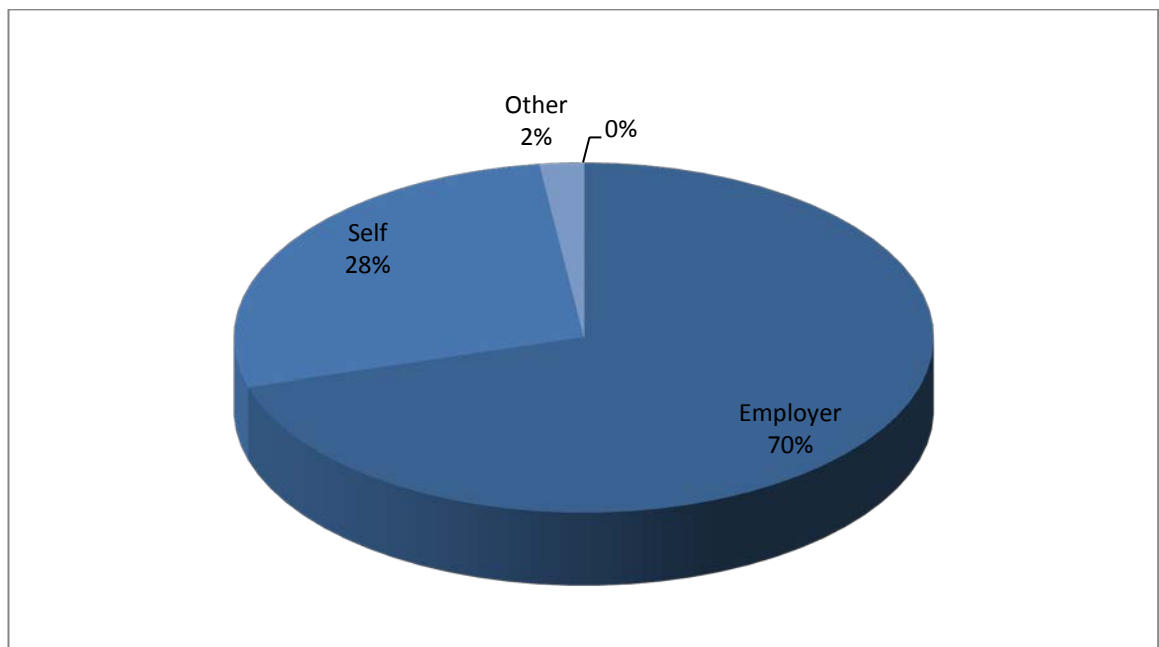


Figure 14: CPD funding

The Social Work and Mentorship students were the student groups that were employer funded. These groups were studying single modules which would, once completed successfully, enable them to assess pre-registration students in the workplace. It is a professional, statutory and regulatory body requirement for both professions, and ensuring the correct ratio of mentor/assessors to students in the placement area is a key factor in ensuring high quality placement learning experience in pre-registration nursing and social work programmes. As such it is no surprise that students on these two modules were funded by employers. The student groups whose studies were more likely to be self-funded than employer funded were those on longer degree programmes at undergraduate

or postgraduate level. Limited CPD funding may also mean that employers are inclined to spread the CPD funding across a team, with each member being funded for one module, rather than to focus the spending on one or two individuals who wish to take undertake longer degree programmes comprising multiple modules. Nevertheless, an employer is likely to estimate the cost of investing a significant proportion of CPD funds in a single person on a single long programme against the outcomes and benefits to the organisation, for example in terms of service improvements and/or achievement of unit, ward, department or Trust strategic objectives. The literature on perceptions of CPD and the potential benefits to the organisation in terms of service delivery and organisational objectives is discussed by Munro (2008) and Gould et al. (2007) and it is possible to interpret the findings of aspect of the questionnaire in this light. Students on longer programmes who were more likely to be self-funding may well be doing so because the benefits of participation and completion are associated with personal, professional and career development rather than achievement of organisational objectives (Gould et al., 2007; Hayajneh, 2009).

Initial healthcare CPD student profile

- Age generally older: 30s and 40s
- Time qualified: 0–10 years
- Funding: by employers for stand-alone modules but may fund own CPD studies for longer programmes.

Dataset 3: Student experience questionnaire demographic data, development of initial CPD student profile

Dataset 3 comprised data from the narrative response elements of each question in the questionnaire. Thematic analysis provided insight in this group of students' perceptions of the healthcare CPD student experience.

5.4 Student experience questionnaire narrative data analysis

The first question in this section asked the students to consider the elements of the student experience and to rank them in order of importance:

Taking into account the 10 elements of the student experience described above, please rank these in order of importance where 10 is the most important or relevant to you as a health or social care CPD student and 1 is the least important or relevant.

Elements of the student experience	Rank from 1–10
○ Engagement	○
○ Communications	○
○ Learning and teaching	○
○ Learning resources	○
○ Support for learning	○
○ The learning environment	○
○ Support services (non-academic)	○
○ Student life	○
○ Sport	○
○ Careers service	○

A review of the range of responses to this question indicated that, despite piloting the questionnaire and obtaining feedback, there were difficulties associated with ranking. Students interpreted the question and how they should respond in different ways, with some respondents ranking the elements the opposite way round to that required, that is, giving a score of 10 to the least important or relevant element and 1 to the most important or relevant. This was despite instructions provided alongside the question. Other respondents gave different elements the same score. As a result, I decided not to include the response to this question in the analysis as the findings were of limited value.

Analysis of free text narratives in the questionnaire provided more insight into student experience in the context of HE than the simple demographic data above. Feedback in response to the question, 'What does the University do well?' indicated that the teaching and learning experience, the quality of teaching and teacher interactions were things that the CPD healthcare student believed the University was good at. There was also positive commentary on remote access to and the quality of UniHub and online tools. There was no mention in any of the narratives of infrastructure or student services. A selection of narratives taken from the questionnaire illustrates this:

Quality of teaching and impact of teaching on my professional development at the CPD level. (Mentorship student)

Tutor availability and willingness to help. (Mentorship student)

E-learning resources—greatly improved since being a full-time student six years ago. Never enough books to borrow. Online access to books—positive step forward. (undergraduate top-up degree student)

Comments on what the University did less well suggested that students were not well informed about services related to sport, student life and careers, which perhaps indicates poor communication rather than dissatisfaction with services themselves and which, based on the feedback to Question 1, they did not rate as important or relevant anyway. Where communication was mentioned, comments reflect dissatisfaction with support services such as finance rather than communication *per se*. Despite identifying UniHub in a positive way, students also mentioned frustrations. Issues around unreliable remote access and lack of availability of books were mentioned in the narratives as things that the University does not do well.

Communication => sorting out finance issues for CPD students. (Social Work student)

Little information about student life, sport or careers services. (MSc student)

[Support—non-academic] Could be improved—especially in financial dept. Several occasions asked to send invoice—but yet to be done. (undergraduate top-up degree student)

Responses to the question about what the University did less well also started to provide insight into the nature of the CPD student experience and seemed to indicate that the experience was not necessarily recognised by the University. Comments in this vein tended to come from Social Work and Mentorship students:

Doesn't take into account the pressures on PAs (practice assessors) at work—i.e. expected to produce high quality work when students have higher support needs. (Social Work student)

One submission date for someone in full-time employment does not take into account workloads and responsibilities within the organisation. (Social Work student)

Engagement: Working in a full-time job and mum. Leave coursework at the very last minute = puts a lot of pressure on me. (Mentorship student)

Some students did comment favourably, however:

As a mature student, I believe the services that are important to learning are available. (undergraduate top-up degree student)

All well provided. (undergraduate top-up degree student)

The next question provided further insight into the CPD student experience. When asked whether the University recognised the unique needs of healthcare CPD students, students mentioned the needs of the mature student and the impact of studying whilst being in full-time employment. Comments were common on the University not taking into account the reality of the CPD student experience of juggling work and study.

I do not think the University has considered the needs of the mature students and the impacts of full-time employment. (Social Work student)

Students also commented on the need for more flexibility (no detail provided), the need for extensions to deadlines and the need for study days to be designed better to reflect the CPD student experiences:

How full-time nurses juggle work and study isn't really taken into account. Could be more flexible to changing needs of full-time study i.e. getting extensions on academic work deadlines. (Social Work student)

Where students commented positively, they tended to centre on the teaching and learning experience: recruitment and induction (for one module in particular, but not typical), the variety of modules, the number of study days, the availability of pathways and remote access to learning resources:

Well organised recruitment process. Induction and evaluation of the course. (Mentorship student)

Good support with assignments and learning strategies. (Mentorship student)

Takes into account that we are in full-time employment. Communication with students. Good at ID learning needs. (Mentorship student)

The following student's response is positive, but has a sting in the tail:

Courses tailored to meet needs of CPD students. Nothing else to suggest that the University has CPD students in mind when it communicates to individuals in the other aspects of university life. (Social Work student)

In terms of the improvements they desired to take into account their needs, the CPD students discussed timetabling, programming, and access to learning resources and communication rather than the student experience. Examples of comments relating to improving learning resources concerned the availability of books and journals, and library opening hours, for example:

Library—open longer. More books. (MSc student)

Increased availability of e-books—save time going to library at all times. (undergraduate top-up degree student)

For some students, the organisation of the module timetable and the need for more time between study days was an important aspect of the experience that could be improved:

A flexible timetable to give students free time when they come to Uni. (Social Work student)

Flexible approach to fit with full-time work scheme? W/E sessions, longer library hours. (MSc student)

Single days of study—don't work well due to work pressures, shift patterns. Maybe a week long at Uni => more beneficial and days for private study => compulsory to improve level of work at Uni and results and motivation. (Mentorship student)

Support for students with disabilities was also discussed in this context, principally by the Social Work group, presumably reflecting concerns and experiences that directly impacted on that cohort. This was not an issue discussed by any other student group:

More resources for disabled students and guidance information who (how) to get these services. (Social Work student)

Communication was a key issue for some students in terms of student–tutor communication:

Better communication between lecturers to students. (undergraduate top-up degree student)

More engagement and feedback in reading and writing and discussion/presentation => enable confidence. (Mentorship student)

and more generally:

More e-mails re what's going on i.e. discounts, events, etc. (undergraduate top-up degree student)

Surprisingly, study leave and time off to study was not discussed as much as I thought it might. This may be because the majority of students in the sample were accessing stand-alone, employer-funded modules when study time was given for what were perceived to be 'important' CPD modules crucial to the smooth running of other programmes and benefitting the organisation.

When asked, 'Do you feel like a University student?' a balanced response was noted. Where students said they did not feel like University students, they also said that it did not matter. Where students responded that they did feel like University students, again this centred on activities comprising the teaching and learning experience, for example assignment preparation. In addition, the positive experience of induction and enrolment was mentioned for students on one specific module. The main reasons for not feeling like a University student were: working full-time, age, inability to integrate with University life, family life, work pressures, limited attendance, isolation and not belonging to a cohort. In addition, the lack of recognition of these aspects of the CPD student experience by employers was mentioned.

Analysis of Dataset 4 enabled me to build on the initial profile constructed for this group of respondents.

Dataset 4: Student experience questionnaire narrative data, final healthcare CPD student profile

The healthcare CPD student profile was as follows:

- Age: generally older—30s and 40s
- Time qualified: 0–10 years
- Funding: by employers for stand-alone modules, but may be funding their own CPD studies for longer programmes
- Is usually combining CPD study, full-time work with home and family responsibilities
- May have limited time to focus on CPD studies
- May only be accessing the University once a week for a half or full day
- Has limited time to use the learning resource services when at University
- Does not necessarily see themselves as typical university student i.e. full-time, undergraduate, three-year, requiring access to the full range of student services.

I anticipated that constructing and disseminating a healthcare CPD student profile, based on healthcare CPD student feedback, could be used in two ways. First, it would enable healthcare academics to tailor curriculum planning and development to the needs of the CPD student generally. Second, it could be used by University and School academic planning and approval committees to make judgments about the quality and ‘fit’ of proposed provision to the specific needs of the healthcare CPD student. With this in mind I used the findings from this part of the study to revisit the Curriculum Principles Document and Staff Guide and expand Guideline 10 to include the healthcare CPD student profile.

The following is an excerpt from the Curriculum Development Principles Staff Guide:

10. The Student Experience

CDT guidance notes.

- The CDT should provide evidence that they have considered what is required to ensure a positive experience for students undertaking the provision (from the student’s perspective).
- Key to this is recognition of the unique features of the CPD student experience. Students have expressly fed back that they would like the University, healthcare curriculum development and teaching staff to actively and explicitly demonstrate awareness of the fact that CPD students :

- Are usually working full-time
- Are usually combining CPD study with full-time work
- Are usually combining CPD study, full-time work with home and family responsibilities
- Are likely to be taking annual leave or requesting days off in order to attend CPD provision
- May be funding their own CPD studies
- May have limited time to focus on CPD studies
- Need reliable access to the University virtual learning environment
- May only be accessing the University once a week for a half or full day
- Have limited time to use the library
- Need efficient administrative systems to be in place to ensure timely access to University resources
- Do not necessarily see themselves as typical University students i.e. full-time, undergraduate, 3-year requiring access to the full range of student services.
- Where appropriate, the CDT should provide evidence that they have liaised with relevant staff in the School, University or Trust to ensure that as far as possible these requirements have been taken into account.

5.5 Discussion of findings from the student experience questionnaire narrative data analysis

From the questionnaire, where the needs of the CPD student were largely being met was mostly in relation to the one-to-one teaching and the learning experience for this sample, unsurprising given the nature of student participation. However, there seems to be a perception among students that the nature and uniqueness of the healthcare CPD student experience was not fully recognised by the University across a range of services and at multiple levels. The findings suggest that at, an administrative and services level, communication and customer services generally could be improved—although it must be acknowledged that this might also be the case for full-time students. In relation to curriculum planning, development and provision there seemed to be a requirement for a more explicit recognition of the CPD student experience in terms of timetable planning and access to learning resources, as well as more generally recognising and acknowledging the impact of multiple commitments, including working full-time, on the ability to study. The role of the employer is significant in terms of both recognising the healthcare CPD student experience and the impact of combining work, study, and domestic commitments. This is particularly significant in the context of CPD students using days off or annual leave to study where employers are not able or willing to allow students to attend university in work time.

The findings from responses to the questionnaire concur with existing literature, particularly in respect of the 'being on' experience discussed in Chapter 2, where the pressure of combining work, study and domestic commitments was discussed in terms of its impact on the ability to study (Cooley, 2008; Gould et al., 2007; Schweitzer and Krassa, 2010). The experience of the CPD at Middlesex contributed to them feeling neither university students nor part of the University, partly because of their multiple commitments but also because of the nature of their participation. Students also mention not being part of a cohort and the isolation. In the Australian literature, workplace and the resultant professional isolation is discussed as significant for those working in rural areas (Jukkala et al., 2008; Hegney et al., 2010). It is also associated with specific teaching and learning strategies, particularly e-learning without teacher facilitation or co-student contact through communities of learning or enquiry. Wedlake (2010), for example, discusses the importance of teacher and co-student interaction in reducing the perception of isolation that can be associated with distance learning and solitary learning. Whilst these features of the CPD student experience are discussed, the literature does not bring these experiences together in an integrated way as 'the experience of the healthcare CPD student in the university setting'.

The findings also raise questions and ideas for future research, for example does this experience translate across other CPD students in other professional disciplines such as teaching, or is it reflective of the part-time student experience generally? There are also commonalities with the pre-registration experience, particularly in relation to age and possibly family commitments and in the requirement to combine work and study when on placement. The key difference, however, is in the recognition of the pre-registration nursing degree as being a full-time course incorporating theory and practice.

Reading the short, free text narrative accounts in the questionnaire and the insights which these provided indicated to me that the right approach was to conduct a focus group in order to explore the healthcare CPD student's university experience in more depth. Denscombe (2003: 161) identifies the limited nature and shape of the answers as one of the disadvantages of the questionnaire and it was my view that if I were to limit my data collection solely to questionnaires I would miss the opportunity to gain a more in-depth perspective of the student experience. This viewpoint was influenced by the experience being part of different research study where data was collected using a focus group. The results from the focus group were such that the researcher was able to gain a detailed and wide-ranging perspective of students' views and experiences of the phenomenon in question. I was keen to gain the same depth of insight in my study.

5.6 Healthcare CPD student experience focus group: Data collection and analysis

Earlier I mentioned that I had obtained School Ethics Committee approval for the use of focus groups. By this stage, unfortunately, the Committee deadline for data collection had expired and I therefore had to submit a further application to the Committee. Approval was given in March 2013 and the focus group was conducted in April 2013. The group consisted of six healthcare CPD students taking the final module of an undergraduate nursing top-up degree. The nature of the group's CPD experience was likely to mirror that of other healthcare CPD students in the sense that they had undertaken some CPD as stand-alone modules on a module-by-module basis and were now working towards a degree. As such, they were students with a broad experience of the CPD process.

The student experience line of enquiry: insider researcher issues

In relation to this line of enquiry, there was slightly different perspective to the insider worker/researcher to consider. I have already addressed the issue of the advantage of the focus group over the individual interview in terms of overcoming power imbalances that may exist between interviewer and interviewee in one-to-one interviews. The issue that needed to be considered in relation to students in both lines of enquiry was how 'outsiders' perceived me as an insider worker/researcher. It was possible that outsider participants viewed me as aligned to the organisation or representing the University. The challenge, therefore, was to conduct the research in such a way as not to appear as the mouthpiece for the organisation, whilst still tacitly acknowledging my role as an insider worker. With all stakeholders I was clear and honest about my dual role as DoP and as researcher, and explicit about the fact that the purpose of the research was to obtain a clearer picture of the nature of the healthcare CPD student experience and, based on the findings, to identify strategies that would facilitate improvements.

I had some on-going concerns about being module leader, programme leader and DoP for this group in terms of potential influence and bias. A key issue, for example, was the possible perception of the students that their answers might influence my assessment of their grading: they might think that they had to 'say the right thing'. The nature of the relationship between the students and me was such that I was fairly confident that they would be honest about their experience, but my concerns were not fully alleviated until I read the focus group transcript. The participants' responses and the flow of the discussion did not appear to have been influenced by my presence or my role in any way. My choice of a focus group over an interview was an advantage in this context. In addition, I was not

asking them to discuss their experiences on the degree programme. What I wanted to explore with them was their perception of the CPD experience more broadly. That said, my role as insider cannot be ignored and needs to be taken into account.

Focus group findings

The transcript of the focus group discussion was read and re-read several times with the aim of identifying key issues emerging from the discussion. The issues were then considered and, where possible, related issues collapsed into categories and finally overarching themes. Some issues constituted a theme without underlying categories. Seven themes were eventually identified. This was the fifth dataset.

Dataset 5: Student experience focus group, development of healthcare CPD models

Adding the focus group delayed the end and writing up, but was worth it for the quality of the results and new perspectives and insights into the healthcare CPD student experience.



Figure 15: Categories and themes from focus group data

Employer engagement and interest

This area of discussion centred on interaction and engagement with employers. There was a perception that employers were not particularly interested in CPD students and their studies, regardless of whether they were funding their studies or not.

(P = Participant)

P6: Not at all, they don't want to know but they know you are studying towards something, but because they really go in to it they have to help you with it, finance, so they just know you are studying in your own time and you are self-funding so they don't want to know.

P2: They've funded all mine and no one has ever come and said to me, how did you get on with this one?

VB: Doesn't that not bother you?

(General laughter and agreement.)

P6: In my experience if it's a single module that's to help with your practice they are more interested.

P1: But mentorship is one of the mandatory training in our Trust now, isn't it. I wasn't funded for it even when I finished mentorship I am actually the one who went to my manager and said could you give me a student I am now a, you know like,

One student had a different more positive experience:

P4: I want to be a bit more positive about where I work as I think they are very encouraging and they are quite nice and people are interested so... and I think that generally the Band 7s and the bands, and you know, the more senior management are interested, they know you're doing a degree, their interested in what you're doing and offering help, so I want to be a bit more positive! They're nice, they're positive.

Perceptions of self as a university student

Comparisons featured strongly in terms of their previous experience of being a full-time student, usually on a full-time pre-registration nursing course. The CPD students in the focus group did not see themselves as being University students or part of the University in the same way as they were when on a full-time course, because of the nature of engagement and ability to participate.

It's not like when you are going to school, as you say, then it's a school and you're just thinking of school. Yes, we're not able to participate in a number of other things, like when we got the information pack they tell you about all the things that is happening there, even the feedback sheet that we filled out to say how did you do this, how was orientation, what happened there. I think most of these questions are not able to answer because I am not involved in it. **I'm not in this part of the University** like when new students are coming in full-time university. It is different and it is just going to be different.

you don't really feel like, I would say, **a proper student**. Being a CPD student is quite different from being those students on the long [course].

P2 **You don't feel part of the University** when you just come in once a month or you're just coming in for that module, for that couple of hours and then you go home. But I don't feel like a student like I did when I was training. '

P4 It's quite different to being a **pre-reg student** in that respect because that is just what you're doing isn't it, **you're being a student** and doing your placements.'

P1 I don't, whereas before I graduated I was here every day and, you know, was in a lot of the time at the library so I **actually felt part of**, you know, the student of [redacted], whereas now I just come for the CPD once a week or every other week as some modules are and go home so...'

The way in which CPD is structured and delivered contributed to the feeling of not really feeling like a university student:

P3: I think it's maybe the way the whole study has been structured. We come in once, let's say this one is once a month, previous ones have done maybe once a week or

once in two weeks... Soon after the lectures everyone packs their bags off they go. So you don't really meet other students.

One student, however, seemed to suggest that not feeling like a student is an inevitable consequence of undertaking CPD studies:

P5: I don't know if it matters anymore because people do different modules and they'll always be, I might be here today with them but I'll, next time I'll have a whole, I think we expect that as postgraduates by now.

Some of the issues discussed here reflected strongly those which were discussed in the free text narratives of the questionnaire for example not feeling part of the University. However, a wholly new perspective was the comparison between being a pre-registration student and a CPD student in terms of the nature of participation.

Identity and the lone study experience

Further insight into the CPD student experience that came through strongly in the discussion was the loneliness of the CPD student. Isolation and not having a sense of belonging were also discussed. These students talked about having an identity and a sense of belonging when they were on full-time programmes, which was not the case for CPD study:

P4: Well you have an identity don't you, you become part of that cohort, that group of people and then you also, in my training, because it was in '91, you were part of the hospital as well, although we did the Diploma as part of Project 2000, we were part, we trained at [REDACTED], we felt an identity at the hospital, so you sort of had, that was very different.

The sense of identity with the School of Nursing and the training hospital seemed to be particularly meaningful in the sense that there was potentially, as a CPD student, a double loss of identity.

The sense of loneliness and isolation applied to their experiences both on and off campus.

On campus:

P3 :I've seen the students in groups discussing whatever needs to be discussed as a group, which I think they do come out with something, whilst you sit there as a lone student trying to get something out of what you've been taught or trying to follow a structure.

P4: I know what you mean because it does make it more of a lonely experience because you try to get on and do it, but then you feel a bit more stressed, a bit more under pressure because there is less sharing, of like, which makes it quite hard.

And off campus: Participants discussed the experience of studying in isolation at home, without the support of other students who you know well and have got to know by virtue of being in a cohort on a full-time programme.

P2 :you're on your own at home, when you're, like for the dissertation it's quite hard when you're on your own at home and you're looking at it and you're like, ummph, you've got sort of no one that you can, sort of, like if you're in class or if you, like know people in your class you could sort of ring them up and discuss it or arrange to meet so you've got someone to fall back on.

Some participants found it difficult to apply themselves to the study task and to focus when studying at home:

P2: But also when you're coming in to Uni just for lectures and then you've got your independent study time, I find sometimes it's hard at home to study as well. You know, like to focus yourself, to make yourself study.

Time, commitment and work pressures

Also significant was the difficulty in finding the time to study and to apply oneself to study because of full-time work, childcare or other domestic commitments. Participants also described the importance of planning in advance and setting time aside to study in their busy lives:

P1: It's different from pre-reg because when you are there you are there full-time student, so don't have to think 'oh I have to work tomorrow so I have to get through this load of work'. And again combined with your housework and then you say 'oh tomorrow I have to go to work **so have only this many hours to finish this so you know, you always have to set yourself time and give yourself deadline to get through it otherwise it's impossible.**

They also describe going 'off plan' because of other commitments.

P3: I have a 4-year-old son and I might go home to today and I'm not working tomorrow and I'm thinking tomorrow's the day to do, and then something may happen, maybe he's ill, if he's not gone to nursery, as soon as he's gone to nursery I need to do some and then look it's 3.00 and it's time to pick him up from nursery. I didn't even get to do what I wanted to do and planned so it's more family commitment as well.

This aspect of studying at home and the impact of other commitments is probably not unique to CPD students. Full-time students can also have other commitments—especially in nursing and midwifery at Middlesex University who, I would claim, are often mature students with families. The experiences described in many ways may relate to this group too. It is not about CPD or full-time, but about study with or without commitments. But the difference is that the full-time students' 'job' is to study and there is likely to be more time in the programme to study at University, which appears to be different for CPD students. For CPD students, time or lack of it featured strongly in the discussion. They talk about

time in terms of full-time students having more of it, shortage of time in terms of rushing to attend class after work, rushing off to collect children after class, lack of time to interact with class colleagues and time to study. The feeling was one of never having enough time, and time as the enemy:

P4 They're a full-time student so they have got **time to sit and chat** with their ermmm, like we talk to our colleagues at work and stuff. **So in a way they have more time**, they're on less of a, **I think we're all rushing in here to do this, maybe come from work**. I've been at work this morning and you come here for the afternoon. You know, we haven't got, **been given much study time** towards it.

P3: I agree with you because sometimes when I come here as soon as the lesson is...

Curriculum design and delivery

The use of particular teaching and learning strategies also had implications for time. Group work, for example, was a particular challenge for those with other commitments, especially when students were expected to do this outside of class time:

VB: I hadn't really thought about this, but in terms of the way in which teaching, the teaching and learning experience is organised, is group work outside of the class time more difficult for you guys?

P2: Yeah because everybody is working different shifts and it's hard, people come from a long way and sometimes it's really hard to all arrange to meet as a group,

P5: and childcare, childcare's a big one.

Students gave suggestions on how the CPD timetable might be planned to facilitate on campus learning and study.

P4: Yeah I think it's if you come in, as we've discussed earlier, we do the morning session teaching and then maybe the afternoon session like a group discussion where we bring our topics together and we discuss it together because as soon as we leave we don't meet 'til about 2 weeks' time or something and you've got other commitments and sometimes you go home and you just put your work away 'til you are ready to come back again, that's when you rush to go through things, so if it's a day's lecture then you can do the teaching then in the afternoon

VB: So a full day, where the morning is taught and the afternoon is more, sort of, networking, sharing,

P4: Would there be anything in having some protected time as part of the dissertation as the four afternoons but saying making it four days but the students get a couple of mornings that their employers kind of have to give them so they get the opportunity to do some study?

This approach, it was suggested, may be workable for students being given study by their employer but, for students who are studying in their own time, there is no real benefit to timetabled study periods:

P1: It's different for us because we're doing it in our own time so, but I myself, let's say if I'm coming here for a lecture I would say 'OK if I'm early when I finish I'll have my lunch and probably this afternoon I have to sit here and do the work in order, you know, for me to catch up with what happened that classroom and continue with what I want to do because for me there is no time given from work so it's all in my own time.

Students indicated significant variations in the amount of study leave given by employers, ranging from time to attend all classes to no time at all. Students also reported differences in study leave allocation by employers at various points in their personal CPD journeys:

P1: So it's all in my own time.

P3: No, we have 50%.

P5: This one I have [had time given by employer], all of the other ones I did.

In addition to in-class group work, networking, discussion and study opportunities were suggestions about teaching and learning strategies that would enable students to interact and support each other remotely:

P6: We did with [redacted] use the discussion board

P6: Everyone was bring their ideas on what had to be done and [redacted] always respond

P4: We had to put things, upload things on to it as well, didn't we?

VB: Right, OK... did you gel more as a group because of that?

P6: Yeah because anytime, we do go on it most of the time so that by the time we come back to class we really have an idea of what we've discussed already or what we are about to discuss and everybody is putting in some input, so it really did.

Online learning resources generally were welcomed as having a positive impact on the learning experience compared to hard copy books that require the students' physical presence to borrow and return:

P4: I think that's very good, I think that's actually, yeah, the development of the website, from having done courses here over the years, I did my contraceptive course here and gendered health and welfare course quite a long time ago and that, you can just see, that's a good progression I think. The UniHub and the fact you can get so many of the resources online, you can hand in your essay online, library stuff, I think that's good, very good

P1: Erm, I don't think with respect to library uses, and well books, because you know we are not here every week so when we get the books... so I think they should look into when we're not here, yeah, longer term loans or in a simple reason because sometimes the book is not available when we order it we are not here to pick it up you actually just have to make that extra journey either to come and return the books or just to get the book.

Despite the difficulties associated with many aspects of the CPD experience, students also talked positively about the way in which the CPD curriculum generally was planned and delivered. APL, individualised pathways and flexibility of provision were examples of this. I suggested that the way that CPD was organised might be convenient for students:

VB: OK, so, the, 'in out-ness' of CPD, erm, is that convenient as well?

P2: Yeah.

VB: OK.

P2: It is when you're working.

(General agreement)

This suggested that CPD students may have to make trade-offs; the convenience of being able to choose what is studied and when may be traded off with the loneliness, lack of cohort support and the somewhat the fragmented nature of the experience.

Experience of University services

Not surprisingly, students had much to say about fees and funding. In the same way that there was variation in opinions in relation to study time allocation, CPD funding ranged from fully self-funding to fully employer/NHS funded and everything in between.

P3: Yes, self-funded, my whole CPD.

P4: I'm quite appreciative now I've had a bit of help towards it so I think, and time towards it, so I think that actually I feel a bit happy about it whereas in the last module I paid for myself and I think I did it in my own time so...

There was also variation in the way that the University services managed payment of fees, particularly in respect of the ability to pay in instalments. Students also reported variation in the way that University services managed late payment of fees. This is likely to be challenge for a student when working full-time and attending class half a day or week, with no time to do anything other than attend class—particularly if they have to leave the University immediately after class to fulfill domestic commitments or return to work:

P3: How, um, financially how the University does not help is they do not allow you to pay, like, in parts.

PX: Exactly.

PX: You have to pay everything in one go.

PX: It's a lot of money to pay.

P5: So especially now the fees went up, it's just crazy, how.

One student described her experience of dealing with University services when her employers were late paying her fees. She describes the impact of being 'blocked' from accessing student systems.

P3: And they don't have, I find, personally for this semester when I had to wait for my employers to pay for my fee and until recently I went to the student office to find out what's happening... they told me that I need to ring the number in [REDACTED] and by the time I get through to them they've blocked me and I wasn't able to access anything on the University campus and things like that. I think, I could find my results, I even had to speak to Venetia about it and then until it was sorted about a week after that I was able to access things again. But I think they should consider, I mean it's a lot of money, it's a lot of money.

P5: And also you can't get books from the library when you're blocked you can't access the books.

P3: You can't do nothing.

P3: Because I'm not the only one, when I did the last, um, the last, um, module there was another girl there who said they wouldn't allow her to pay instalments as well, she had to pay everything all. I had to pay £1225 all in one go.

Other students had a different experience:

P6: For me it's quite different for, because they were quite flexible with the payment.

P6: Yeah, I had a different experience, they were very flexible, I have been paying it in instalments.

There was evident frustration around communicating with University services.

P3: I would say it is not done well there is not much information provided that if you want to speak to someone, you can do that.

P1: Sometime when you phone the student office for the information, like when I did my contraceptive course because I deferred because I went to have a baby and then on the phone they didn't know about me because I was also in line to start in the January because I had deferred the previous year and I had to go round and round and I couldn't find any information until I got in touch with the module leader

The impact of CPD on job and career

An interesting section of the focus group concerned the impact of completing CPD studies. Some respondents felt that CPD, and particularly a degree, would not make any difference to employers or to the job but might make a difference in the long term. They do not specify in what way:

VB: OK, so your degree and having a degree will be a huge achievement... but the employers....

P6: But not to the employers.

P2: It's not going to make any difference to your job.

VB: It's not going to make any difference to your job at all?

P4: I think it might, I think it might. It will, in the long term.

When asked about the impact of CPD on career progression, some students agreed that CPD might have a positive impact in terms of employability:

VB: Do you see it as a way of giving you career progression? Do you think having a degree will help you in your employment?

There was agreement.

Data collection and analysis for the student experience line of enquiry finished April 2013.

5.7 Discussion and Implications of findings

Analysis of data from the focus group resulted in three significant outcomes. First, some of the findings supported and were consistent with the findings from the questionnaire, specifically the findings related to University services; CPD student commitments and feelings about being a University student. The focus group discussions gave depth and detail to the questionnaire findings so that a much richer picture of the CPD student experience emerged. This enabled me to gain a deeper understanding of why students did not feel like proper University students, of the impact of multiple commitments on the study experience and student perceptions of University services. Second, findings supported themes discussed in the literature in Chapter 2. Third, the findings generated new knowledge of the healthcare CPD experience—this was present in neither the literature nor the questionnaire findings, for example the lone study experience.

The focus group findings supported the literature in terms of potential benefits that CPD may provide to employers and the organisation (Munro, 2008). There was also the suggestion that, for students in this study, employers were the gatekeepers to CPD studies. Employers could facilitate access to CPD either through the provision of funding or study time and when this did not happen students funded themselves or studied in their own time (Gould et al., 2007; Santos, 2012). Students also suggested that, in terms of the impact of CPD on practice, this was very much at a personal level. There was a perception that completing CPD was or could be beneficial from a professional or career development perspective (Gould et al., 2007; Hayajneh, 2009), rather than clinical practice (Gijbels et al., 2010; Lee, 2011). Where practice was mentioned it was in the context of employers only funding single modules: 'that's to help with your practice'.

In Tame's work on secret study (Tame, 2011), she describes a hostile workplace culture where nurses keep their study endeavours secret from their employers. An alternative

dimension for the students in this study was not workplace hostility but workplace or employer indifference or disinterest. This seemed to be the case, with one exception, regardless of whether or not students were supported with funding or study leave. Where students were neither funded nor given time, it was possible that employers were not even aware that students were engaged in CPD study. It is not possible to provide definitive reasons for this without asking employers themselves, but it might be possible to link employer behaviour to the nature of the Health Service at that time, that is, in the wake of the Francis and the Willis Reports, to say the least, challenging.

The isolation of the CPD student was also a feature in the literature, but discussed in the context of teaching and learning strategies (Glogowska et al., 2011; Wedlake, 2010), particularly e-learning and regional or geographic isolation, rather than in the context of the loss of cohort identity. Students in this study talked about loneliness and isolation, irrespective of type of teaching and learning strategy.

Issues of time and time pressures associated with being a CPD student and the impact of this on the study experience also linked to the literature, where lack of time was a factor that could inhibit access (Schweitzer and Krassa, 2010; Santos, 2012). Time due to multiple commitments seemed to be a key factor in impacting on the ability of the student in the study to engage effectively with CPD studies.

As a data collection method, the focus group, like certain forms of interview, is associated with the ability to gain deeper insights into the participant experience than questionnaires. In this line of enquiry there were definite aspects of the student experience that were identified as themes in the questionnaire analysis and provided some limited insight. In three cases the focus group analysis provided an enhanced understanding of these issues.

Particular insight was gained into the healthcare CPD students' perceptions of themselves as University students. The questionnaire analysis indicated that CPD students did not necessarily see themselves as University students. The focus group analysis gave more detail. What this group seemed to indicate was that there was a difference in the nature of engagement from being a full-time pre-registration nursing student. Students discussed not feeling like part of the University when on CPD courses because of the part-time/ad hoc nature of participation. Participants reported not feeling like 'proper students' as they did when they were attending University every day. As pre-registration students, their identity was wrapped up in being a student. This did not seem to be the case as a CPD student. No doubt relating to this perception was another feature of the questionnaire

analysis that also featured in the focus group discussion. Having to combine full-time work and study with domestic and family commitments featured in the questionnaire narrative texts. This theme was also taken up by the focus group participants in the context of time: setting specific time aside to study in order to accommodate work or family commitments or limited time to study for the same reason. Time being hijacked by unexpected demands was another feature of the experience. Other students talked about having to study in their own time on days off, for example. Rushing off to work or to fulfill other commitments was also discussed.

Finally, in the questionnaire students indicated some dissatisfaction with University services (non-academic), with a number of students suggesting that poor communication was of particular concern. The focus group analysis supported this viewpoint and dissatisfaction was also associated with poor communication; in addition, the management of fee payments was a particular concern, especially in conjunction with what students called 'blocking' of access to University facilities.

Analysis of the focus group discussion generated perspectives that were neither revealed in the questionnaire analysis nor addressed in the literature. Although there was reference to employers and managers as gatekeepers to CPD and also in the context of their contribution to workplace cultures, there was no discussion of managers' indifference or lack of interest, identified as a theme in the focus group analysis. The challenge in this context is in how to facilitate manager engagement with CPD.

Focus group analysis also generated new knowledge in relation to the CPD student identity and the lone student experience. Participants in this study discussed the contrast between their pre- and post-registration study experience. The loss of cohort identity, and the associated loss of group support and sense of belonging, was a key feature of these discussions. There was a strong sense of not being able to call on members of a cohort to discuss studies, share ideas and perspectives on study tasks. The 'in and out'-ness of the CPD study experience was acknowledged as convenient in terms of fitting in studies at a time and place that suited the students' work and personal lives, but this seemed to be a trade-off in terms of the desire to belong to and the benefits accruing from being part of a permanent cohort or study group. The experiences described by the participants suggested to me that they had had to make a transition in the study experience from pre-registration nursing student in HE to healthcare CPD student in HE.

The transition from student nurse to qualified staff nurse is recognised in the literature as being a potentially stressful life event. The Boychuk Duchscher model of transition shock

illustrates the concept. This describes that new nursing graduates move through stages of loss, doubt, disorientation and confusion based on challenges associated with the need to adapt to new roles, relationships and responsibilities and to acquire new knowledge. Transition shock, the author argues, constitutes an early stage within a transition model comprising stages of doing, being and finally knowing. New nursing graduates move through these phases over a period of approximately one year (Boychuk Duchscher, 2008).

Contemporary thinking focusses on the transition from pre-registration student to registered practitioner (DoH, 2010) and preceptorship programmes are seen as essential in aiding that transition. The DoH (2010) suggests that the aim of such programmes is to enhance competence and confidence in newly qualified practitioners to develop their practice. Currie and Watts' (2012) rapid review of preceptorship reports a range of benefits to new nurses in participating in a preceptorship programme, including increased confidence and job satisfaction, and improvements in the delivery of quality care to patients. The challenges associated with transition shock are therefore somewhat mitigated by the participation in a preceptorship programme. The DoH's indicative content of a preceptorship programme has 16 elements. Only one is concerned with CPD. This element should 'enable participants to develop an outcome based approach to CPD' (DoH, 2010: 20), however the transition in the study experience is not addressed.

Drawing on the findings from the focus group in particular, and the narrative elements of the questionnaire, it was possible to construct a model based on concept of transition of the study experience of the CPD student in HE.

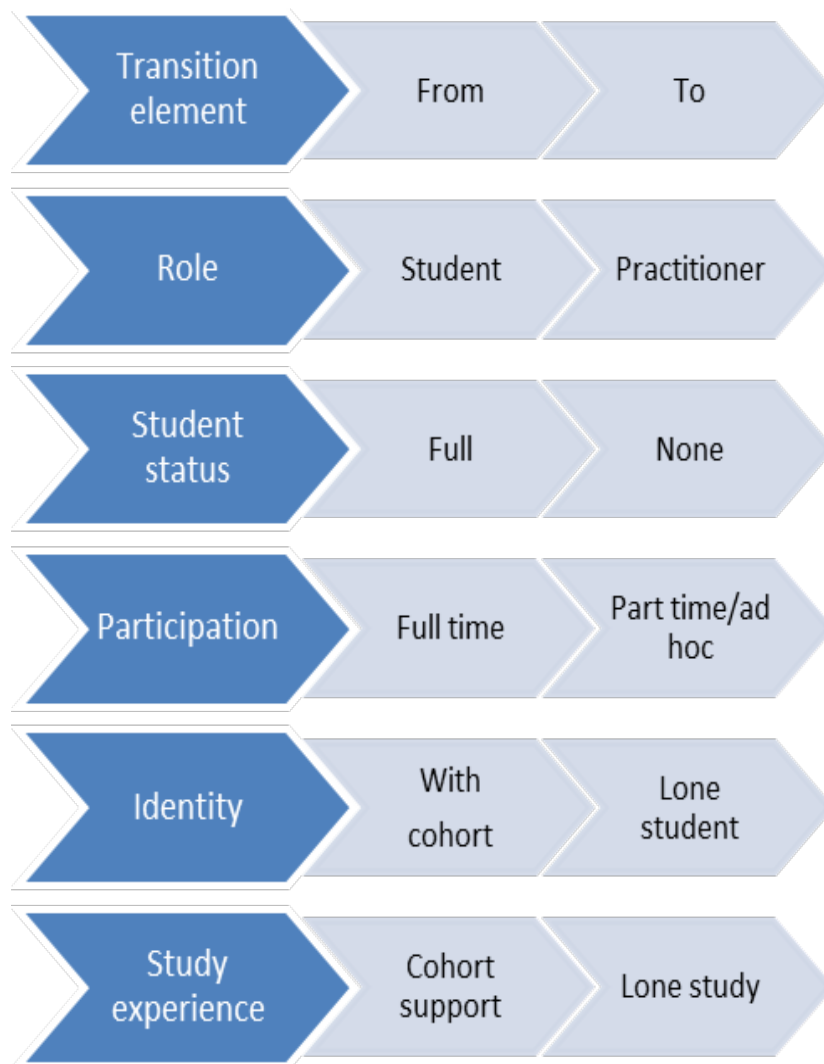


Figure 16: Healthcare CPD transition model

The CPD literature suggests that nurses undertake CPD in order to ‘keep up’ with pre-registration students on education programmes set at a higher level than theirs; to keep up to date with clinical practice; to acquire new knowledge; and to enhance existing knowledge. Participation in CPD is also associated with personal and career development (Gould et al., 2007; Hayajneh, 2009). The professional requirement to engage in CPD is directly linked to re-registration on a three-year basis and, as discussed earlier, CPD can take a range of forms in a range of settings. Based on the CPD transition model, it could be argued that there is discordance between the professional body requirement to engage in lifelong learning and CPD activities, and the reality of that engagement when it takes place in an HE context.

Triangulation and integration

Lincoln and Guba (1985) argue that triangulation is an indicator of credibility, which in turn is an indicator of quality. What follows is a comparison of findings across the whole study to establish points of corroboration. This project aimed to give voice to the students by asking them directly about their experience of studying at Middlesex University. Activity took place mainly during questionnaire and focus group phases of the study. However, the students were also key stakeholders in the stakeholder–curriculum element of the project.

Table 12: Comparison of findings from different elements of the project

Feedback from student-stakeholder group	Findings from the questionnaire	Findings from the focus group
<p>Short—but depends on module content. Commentary: <i>No link to other elements of the project.</i></p> <p>Tutor support— pastoral and academic may affect decision about where to study.</p> <p>Commentary No link with focus group but links to questionnaire where issues relate to what the University does well i.e. support (academic) for teaching.</p> <p>Realistic in terms of hours needed for study/Awareness of non-contact time/add module learning time.</p> <p>Commentary: This element of the student-stakeholder feedback links to student feedback in the questionnaire and to a lesser extent in the focus group.</p> <p>Link to career development.</p> <p>Commentary: This was discussed in the FG in</p>	<p>Employer funding for short stand-alone modules and self-funding for longer programmes.</p> <p>Commentary: was also reflected in the focus group discussion. Mentorship in particular was mentioned in the questionnaire and the focus group.</p> <p>The healthcare CPD student profile from the questionnaire—that is (combining CPD study, full-time work with home and family responsibilities),</p> <p>Commentary: was discussed in the focus group in terms time pressures, part-time access to the University.</p> <p>The questionnaire responses indicated that the CPD student did not necessarily see themselves as a typical University students.</p> <p>Commentary: this was mirrored in the focus</p>	<p>Employer related aspects of CPD a) study day release and b) funding.</p> <p>Commentary: some articulation with questionnaire feedback relating to funding and studying in own time.</p> <p>Perceptions and experiences as a CPD student: a) self as a University student, b) feelings about the CPD student experience.</p> <p>Commentary: mirrors narrative feedback in questionnaire.</p> <p>Curriculum, teaching and learning— design and delivery was discussed in terms of organisation of timetable to include study time and e-learning.</p> <p>Commentary: discussed in the questionnaire in the context of staff recognising the context within which CPD students study.</p> <p>CPD student experience of University services: a) fees and funding, b) information and communication.</p> <p>Commentary: This was also a key finding in the student questionnaire.</p> <p>Impact of CPD on job/career/practice.</p> <p>Commentary: also inferred in student stakeholders feedback where</p>

<p>terms of a passport.</p> <p>Step on and off but still collect credits.</p> <p>Commentary This articulated with the feedback from the focus group around the flexibility of CPD provision.</p>	<p>group responses where there was discussion relating to the student experience being different because of the nature of participation and the multiple pressures which the CPD student faces.</p>	<p>students discuss the importance of a CPD strategy which should reflect the importance of linking CPD to career development.</p> <p>Time pressures and the self/independent/lone study experience.</p> <p>Commentary: No direct link to other elements of the project.</p>
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Through the adoption of a data triangulation approach, and despite the disadvantage of using a within-method approach to mixed method as discussed in Chapter 3, it was possible to identify areas of corroboration that gave weight to the validity of the project, specifically in relation to the student-stakeholder element of the stakeholder–curriculum line of enquiry, which were also features of the questionnaire and/or focus group data in the student experience line of enquiry. Similarly, there were aspects of the questionnaire data that were also reflected in the focus group.

5.8 Integration and final product development

Revisiting the student element of the stakeholder–curriculum line of enquiry for triangulation purposes was significant. It enabled me to consider the integration of the findings from the stakeholder–curriculum line of enquiry with those from the student experience line of enquiry. The final product—the four-point model for enhancing the healthcare CPD student experience—emerged from this integrated whole.

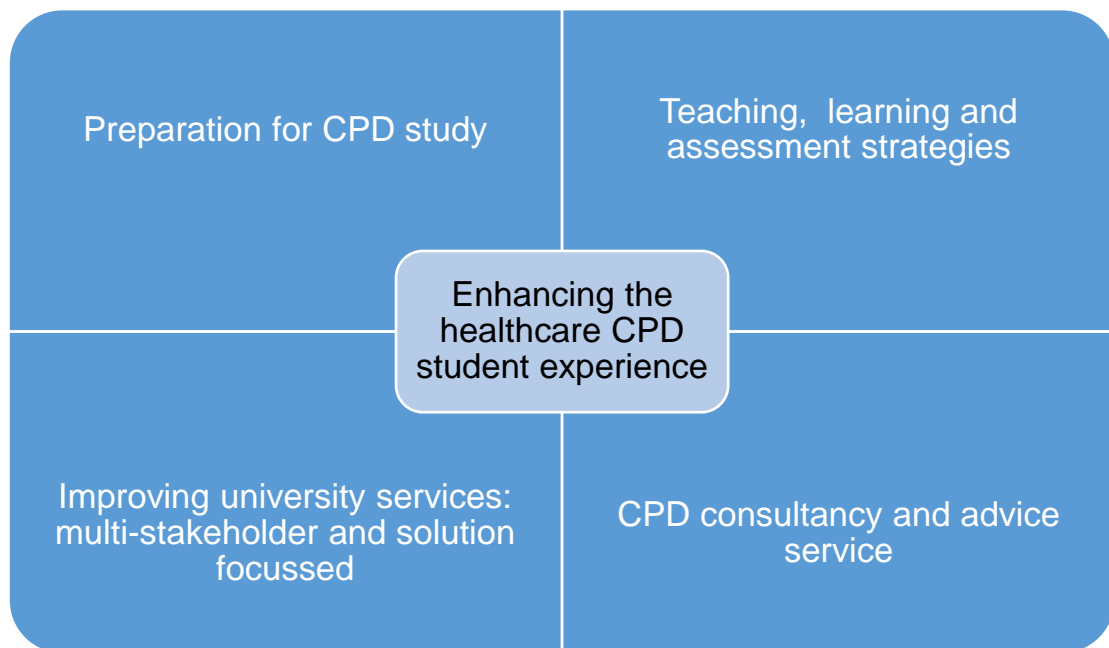


Figure 17: A four-point model for enhancing the healthcare CPD student experience

The model consists of four key elements reflecting different but complementary dimensions of the healthcare CPD student experience, each of which may stand alone. Proposed activities within each element of the model are designed to address issues identified from the findings of the project. The model itself demonstrates the wide range of factors that may impact on the healthcare CPD student experience and the wide range of stakeholders who may be involved in enhancing that experience. The core features of each element in the model are discussed in more detail in Chapter 6 as part of the recommendations.

The findings from each line of enquiry were revisited during the final integration phase. The tables below illustrate the relationship between the data source, the data analysis and how the findings contributed to the development of the four elements of the CPD student experience enhancement model. In Tables 13a and 13b the direct link between the findings from the stakeholder–curriculum line of enquiry and the questionnaire element of the student experience line of enquiry is shown. Table 13c shows how, of the seven themes emerging from analysis of the focus group transcript from the student experience line of enquiry, three contributed to the development of the CPD transition model, which in turn informed the four-point model. The preparation for CPD study element of the model was specifically developed to address the issue of transition, as were key strategies within the teaching, learning and assessment element. The four remaining focus group transcript themes directly linked to the four-point model. This is also shown in Table 13c.

Tables 13a-c: Relationship between data source, the data analysis and how the findings contributed to the development of the four elements of the CPD student experience enhancement model

Project Line of Enquiry (LoE)	Data source	Category (derived from analysis of data)	Theme (from collapsing categories)	4-point model element
Stakeholder–curriculum LoE	Professional conversations with key stakeholders (PC)	Professional applicability	Focus of provision: What	Teaching, learning and assessment strategies
		Practice related		
		Trust-service objectives		
		Nature of provision: design, delivery, facilities	Focus of provision: How	Teaching, learning and assessment
		Participants/audience	Focus of provision: Who	Preparation for CPD study Teaching, learning and assessment
		Marketing of staff expertise Portfolio of offer Marketing and communication	Marketing	CPD consultancy and advice service

Table 13a

Project Line of Enquiry (LoE)	Data source	Analysis	Results	Product (from LoE)	4-point model element
Student experience LoE	Questionnaire (demographic data)	Simple statistical analysis	<p>Largest age group: 30–39</p> <p>Length of time qualified: 0–5 years</p> <p>Funding: Employer (stand-alone modules), Self: longer programmes</p>	Initial healthcare CPD student profile	
	Questionnaire (free text narratives)	Thematic analysis	<p>Multiple commitments</p> <p>Limited time to focus on CPD</p> <p>Part-time participation</p> <p>Limited time to access learning resources when at University</p> <p>Does not see self as a 'typical' University student</p>	Final healthcare CPD student profile	Teaching, learning and assessment strategies

Table 13b

Project Line of Enquiry (LoE)	Data source	Analysis	Themes	Product (from LoE)	4-point model element
Student experience LoE	Focus group transcript	Thematic analysis	Perceptions of self as a University student	CPD Transition Model	Preparation for CPD study
			Identity and the lone study experience		Teaching, learning and assessment strategies.
			Time commitment and work pressures		
			The experience of University services		Improving University services: a multi-stakeholder, solution-focussed approach.
			Employer engagement and interest		Teaching, learning and assessment strategies.
			Curriculum design and delivery		
			Impact of CPD on job/career		CPD consultancy and advice service.

Table 13c

5.9 Concluding comments

In this chapter I have taken an integrated approach to the implementation and findings of the student experience line of enquiry. The student transition model was developed as a result of this work. The later sections of the chapter focussed on triangulation of findings from both lines of enquiry and demonstrate that the findings from one line corroborate the findings from the other. The triangulation activities were instrumental in drawing the two lines of enquiry together to form an integrated whole and, as a result, a final product was developed —a four-point model for enhancing the healthcare CPD student experience.

Chapter 6 The Healthcare CPD Student Experience: Discussion, recommendations and products

6.0 Introduction

The original and overarching focus of this project was the healthcare CPD student experience. It developed into a project within which there were two lines of enquiry. The first was directed towards uncovering meaning, enhanced understanding and subjective perceptions of the healthcare CPD student experience *from the students' point of view* (the student experience line of enquiry). The second aspect also related to subjective perceptions but this time from a wider range of 'stakeholders', all of whom had a valid interest and stake in the issue of curriculum strategy development, design and delivery (*stakeholder–curriculum line of enquiry*).

Workforce imperatives resulted in the stakeholder–curriculum line of enquiry taking place before the student experience line of enquiry. The project was conceptualised and is reported as two separate lines of enquiry running in parallel. In reality I moved between the two lines of enquiry at various points over the course of the project. The focus was in the main determined by workplace events and the academic calendar. Specific findings from each line of enquiry resulted in the development of three products, identified in yellow in Figure 18 below. Through the integration of key findings from each line of enquiry, a fourth and final product was developed, as seen in Table 14.

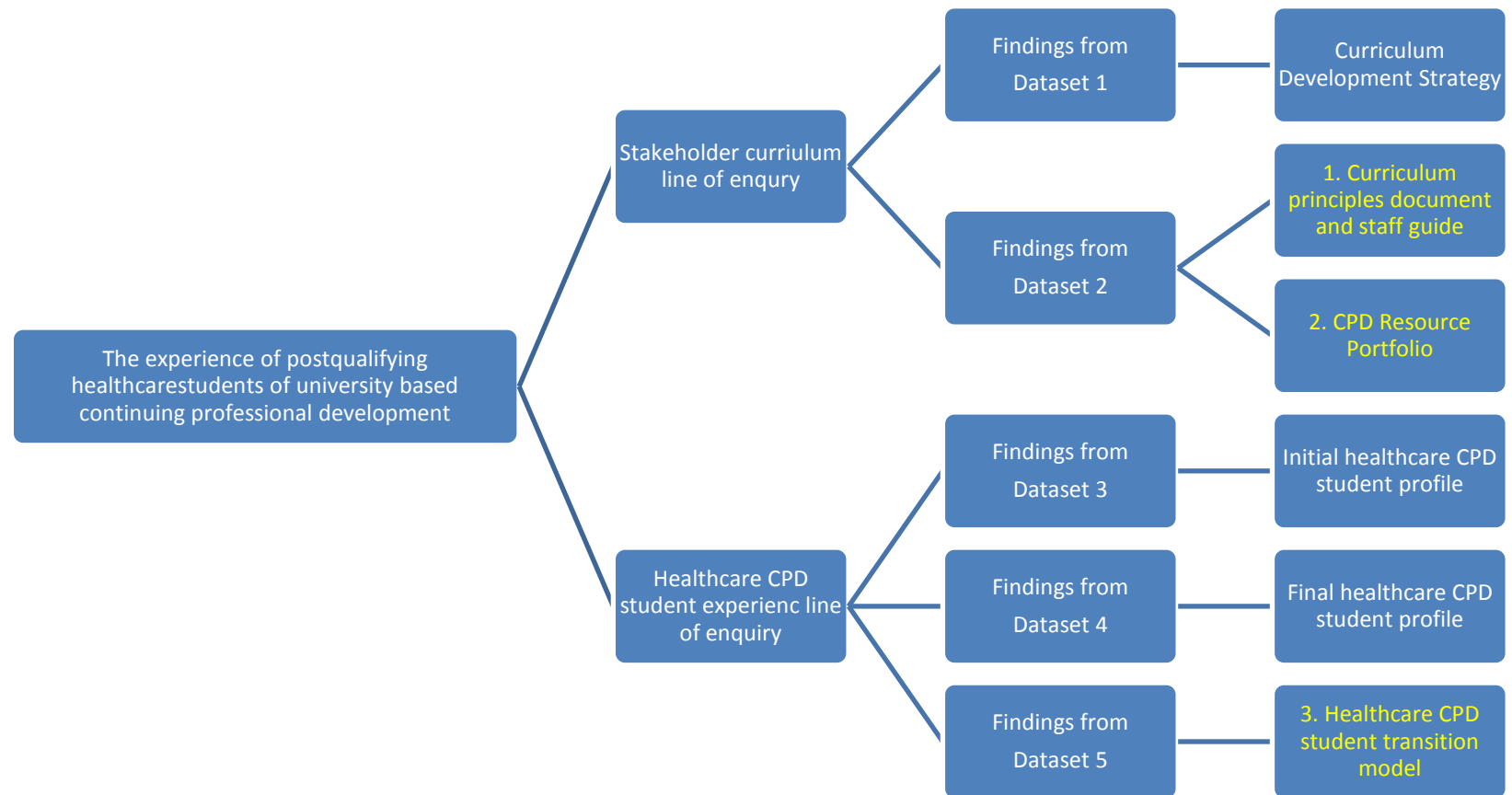


Figure 18: Project overview and Products 1–3

6.1 Product 1: CPD Principles

Table 14: Product 1, Healthcare CPD Curriculum Development Principles

Core healthcare CPD curriculum development principles
<p data-bbox="320 376 1062 409">Healthcare CPD education and training provision should:</p> <ol data-bbox="320 409 1382 477" style="list-style-type: none"> <li data-bbox="320 409 1382 477">1. Be professionally applicable, practice related and, where possible contribute to the achievement of Trust/service objectives. <p data-bbox="320 510 1401 712">All healthcare related curriculum development should be able to demonstrate relevance to practice and ideally changes in health care practice such that it enables organisations and Trusts to move towards meeting objectives at strategic, unit, service or individual practitioner levels. How this occurs should be clear from the onset of the curriculum development activity and this objective should be easily recognised by the purchaser.</p> <ol data-bbox="320 745 1283 813" style="list-style-type: none"> <li data-bbox="320 745 1283 813">2. Be financially viable and should represent good value for money for the commissioner, purchaser or funders. <p data-bbox="320 846 1394 913">The education provision should be costed so that it represents value for money for the purchaser in addition to being cost effective to the HEI to run.</p> <ol data-bbox="320 947 1222 981" style="list-style-type: none"> <li data-bbox="320 947 1222 981">3. Enable the student to progress academically and/or professionally. <p data-bbox="320 1014 1410 1283">The education provision should be planned in such a way as to enable students to progress from one unit of study to another. This may be from non-credited to credited provision or from credited provision at module level to the attainment of an academic award at either UG or PG level. Consideration should be given to the use of the University accreditation process at individual and organisational levels. Similarly, consideration should be given to use of the University AP(E)L processes. Where possible planned provision should demonstrate to the purchaser how unit/module/programme facilitates academic progression.</p> <ol data-bbox="320 1317 1358 1350" style="list-style-type: none"> <li data-bbox="320 1317 1358 1350">4. Be designed in such a way as to enable access at study day or module level. <p data-bbox="320 1384 1410 1518">The education provision should be designed to reflect the recommended curriculum development model where each module consists of a series of discrete but linked/related study days that students may access on an individual basis. Alternatively students may access the full module with the associated assessment.</p> <ol data-bbox="320 1552 1390 1619" style="list-style-type: none"> <li data-bbox="320 1552 1390 1619">5. Be designed so that students are exposed to a variety of teaching, learning and assessment strategies. <p data-bbox="320 1653 1410 1753">Curriculum developers will ensure that provision is planned to reflect the philosophy described in the relevant University and School LTA policies in order to reflect the diversity of the student population and their varied learning styles and needs.</p> <ol data-bbox="320 1787 1023 1821" style="list-style-type: none"> <li data-bbox="320 1787 1023 1821">6. Be designed with the audience/participants in mind. <p data-bbox="320 1854 1410 2047">Curriculum developers will ensure that provision is planned to reflect the needs and requirements of the CPPD/PQ student. Developers need to take into account the CPD student experience including the need to recognise the fact that many are accessing provision in their own time whilst at the same time working full-time. CPD students may only be in the University for half to one day per week and will need University systems to work effectively and efficiently if they are to get the most out</p>

of their University experience—especially in respect of enrolment, learning resources, learning support and e-learning. Where relevant students will need early access to learning support. Consideration should be given to embedding this in the education provision if possible.

7. Be designed in partnership.

The value of partnership working cannot be underestimated. Partners may include all key stakeholders: clinicians, students, Trust Managers and where relevant service users.

8. Be of the highest quality.

High quality provision encompasses a variety of aspects including the teaching, learning and assessment experience as well outcomes which enable those that have accessed the provision to apply learning to practice and to make a positive difference to the service or to service users.

9. Be appropriately quality monitored.

Curriculum planners should be aware of the range of external organisations who are involved in quality monitoring our provision—these include PSRBs such as the NMC and funding organisations such as NHSL. In addition they should be familiar with and respond to internal HEI systems and processes for monitoring the quality of credited and non-credited provision.

10. Be delivered by staff with relevant and appropriate expertise.

Purchasers should be assured that all our provision is delivered by staff that have relevant and appropriate expertise both as teachers and as subject specialists. This might include staff from other Departments within the School or from other Schools in the University.

11. Be marketed effectively.

Curriculum developers should liaise closely with the School Marketing team in order to ensure that new provision is effectively marketed, using a range of media, internally to colleagues in the Institute of Nursing and Midwifery and to other colleagues School with School and externally to purchasers.

12. Complement existing provision.

Curriculum developers should be aware of the focus and nature of our 'offer' in healthcare education and training provision and should be able to demonstrate internally and externally how planned provision complements existing provision and draws on our strengths and areas of expertise.

13. Contribute to a positive student experience.

Curriculum developers should be able to demonstrate what steps have been taken in developing the provision to contribute to a positive student experience.

6.2 Product 2: Staff Guide



Table 15: Product 2, Staff Guide

Institute of Nursing, Midwifery and Social Work

School of Health and Education

Nursing, Midwifery and Health Continuing Professional Development

Curriculum Development Principles

Staff Guide

Guidelines for all staff involved in the development, delivery and quality monitoring of post-qualifying/postgraduate health and social care continuing professional development provision

These guidelines aim to:

- Provide guidance for PQ/PG staff engaged in the PQ/PG health and social care CPPD curriculum development work.
- Provide criteria which can be used by the relevant HSSc Committees to evaluate new and reviewed proposals.
- Provide evidence to funders, commissioners, purchasers and other key stakeholders that Middlesex/HSSc PQ/PG healthcare CPPD provision is based on a strategic model which reflects the needs of key stakeholders.
- Ensure that provision is sustainable, provides value for money and is of the highest quality.

Advice Healthcare CPD Curriculum Development Teams (CDT)

Please use these guidelines at the start of your curriculum development activities. They should be used to guide the full range of planning and development activities from initial planning including identification of the planning team, through curriculum design, document production and validation/approval.

It is expected that teams will include discussion or evidence of the use of the curriculum development principles in relevant V&R documentation. This could be the initial overview or critical review document produced in conjunction with either a new module or APAC form. Other evidence may be included in student programme handbooks. School V&R scrutiny committees such as APC and V&A will use these as part of the assessment and scrutiny process.

CDTs should also provide guidance for scrutiny panels on where evidence can be found i.e. which document and what page numbers.



Please use these guidelines as part of the scrutiny, assessment and approval process. It is expected that teams will include discussion or evidence of the use of the curriculum development principles in relevant V&R documentation. This could be the initial overview or critical review document produced in conjunction with either a new module or APAC form. Other evidence may be included in programme handbooks.

Name and role of person completing the form.

Name:

Role:

e-mail address:

-
-
- **Type of Continuing Professional Development (CPD) provision being developed**
- **(e.g. study day, module, programme, credited/non-credited, contract/non-contract).**

1. Is this provision likely to be commissioned/purchased? Were the Sustainability Toolkits used in the development of this provision? If yes, what was the result? If no, on what basis was it agreed to go ahead with the development of the provision?

Curriculum Development Team (CDT) guidance notes

- CDTs should consider reviewing minutes of PQSG meetings or e-mail requests from Education Commissioners (NHS contract, business/knowledge transfer) to provide evidence of need.
- The Sustainability Toolkits have been devised to support the decision-making process in cases where new provision is being considered or where there is a need to assess the sustainability of current courses. The toolkits are meant as a guide and framework, allowing provision to be assessed against a number of key criteria. The Toolkits can be found in the CPD resource portfolio:
- <https://www.pebblepad.co.uk/middlesex/viewasset.aspx?oid=409470&type=webfolio>
- Minutes of curriculum meetings indicating need for an agreement to offer new or revised PQ/PG provision based on key internal or external drivers should be used where relevant.
- Boards of Study minutes may be used demonstrate requests for provision originating through student groups.

CDT commentary

2. Explain how your provision will assist participants to meet Trust/service objectives.

CDT guidance notes

- Provision of evidence mapping planned provision against relevant objectives should be included.

CDT commentary

3. Who is the intended audience and were they involved in the development of the provision? Was your proposal developed in partnership with Trust/clinical colleagues and students?

CDT guidance notes

- CDT could provide evidence of working in partnership with relevant healthcare staff (commissioners, managers and clinicians) from Curriculum Development Team meetings notes.

- CDTs should include, where possible, past, current and future students.
- Evidence could indicate the extent of involvement of all CDT members in the planning and development of provision and, where appropriate in delivery, assessment and quality monitoring.

CDT commentary

4. Please describe how your proposed development facilitates academic progression or enhanced employability (or both)?

CDT guidance notes

- The CDT should provide evidence of how the planned provision will enable the successful student to progress academically, for example from module to programme.
- The CDT should also consider how completion of the provision contributes to professional development and enhances employability and career progression prospects.

CDT commentary

5. Does your proposed development fit the model of study days, which can be delivered as stand-alone days or which can be grouped to form a module (available at levels 6 and 7), which in turn can contribute to an award e.g. Advanced Diploma or Postgraduate Certificate?

CDT guidance notes.

- The CDT should provide a module and or programme structure diagram, with supporting commentary, demonstrating how the provision has been planned. The study day, module (including levels) and award elements where appropriate should be included.

CDT commentary

6. Please explain how the proposed provision will fit within the existing nursing, midwifery and health CPD portfolio.

CDT guidance notes

- The CDT should include commentary demonstrating how the proposed provision complements the existing Nursing, Midwifery and Health CPD portfolio of provision.
- Does it strengthen or broaden a specific aspect of CPD or add a new element?

CDT commentary

7. Has consultation taken place with the School marketing team?

- CDT to provide evidence of consultation and agreement with School Marketing Team regarding the best strategies for ensuring that the provision:
 - Is effectively communicated internally
 - Is effectively communicated externally using a variety of media
 - Has a clear message about relevance of and benefits to Trusts and to clinicians
 - Has a clear message about delivery by staff with relevant expertise

CDT commentary

8. Quality Issues

Are the academic staff sufficiently experienced to deliver provision? For Non-Credit-Bearing Courses, has the relevant document been completed? Which University mechanisms will be used to monitor and enhance the quality of the proposed provision?

CDT guidance notes

- CDT to provide evidence of consideration of the requirement for quality monitoring, assurance and enhancement. The team should comment on:
 - Academic staff experience to deliver the proposed provision
 - Which existing University mechanisms will be used to monitor and enhance the quality of the proposed provision? This may include module and programme evaluations; Boards of Study; external examiners reports.
 - PSRB and/or other funding body quality monitoring requirements.

CDT commentary

9. Resourcing

CDT guidance notes

- CDT to provide evidence of discussions with Directors of Programmes, Heads of Department or Deputy Deans where there is a need for additional resources in order for the programme to be delivered.
- The team should also consider whether the cost of provision is affordable for self-funding students and whether the provision represents value for money from the perspective of the purchaser and the commissioner.

CDT commentary.

10. The Student Experience

CDT guidance notes

- The CDT should provide evidence that they have considered what is required to ensure a positive experience for students undertaking the provision (from the student's perspective).
- Key to this is recognition of the unique features of the CPD student experience. Students have expressly feedback that they would like the University, healthcare curriculum development and teaching staff to actively and explicitly demonstrate awareness of the fact that CPD students :
 - Are usually working full-time
 - Are usually combining CPD study with full-time work
 - Are usually combining CPD study, full-time work with home and family responsibilities
 - Are likely to be taking annual leave or requesting days off in order to attend CPD provision
 - May be funding their own CPD studies
 - May have limited time to focus on CPD studies
 - Need reliable access to the University virtual learning environment
 - May only be accessing the University once a week for a half or full day
 - Have limited time to use the library
 - Need efficient administrative systems to be in place to ensure timely access to University resources
 - Do not necessarily see themselves as typical University students i.e. full-time, undergraduate, three-year requiring access to the full range of student services.
- Where appropriate, the CDT should provide evidence that they have liaised with relevant staff in the School, University or Trust to ensure that as far as possible these requirements have been taken into account.

CDT commentary

END OF FORM

6.3 Product 3: Healthcare CPD transition model

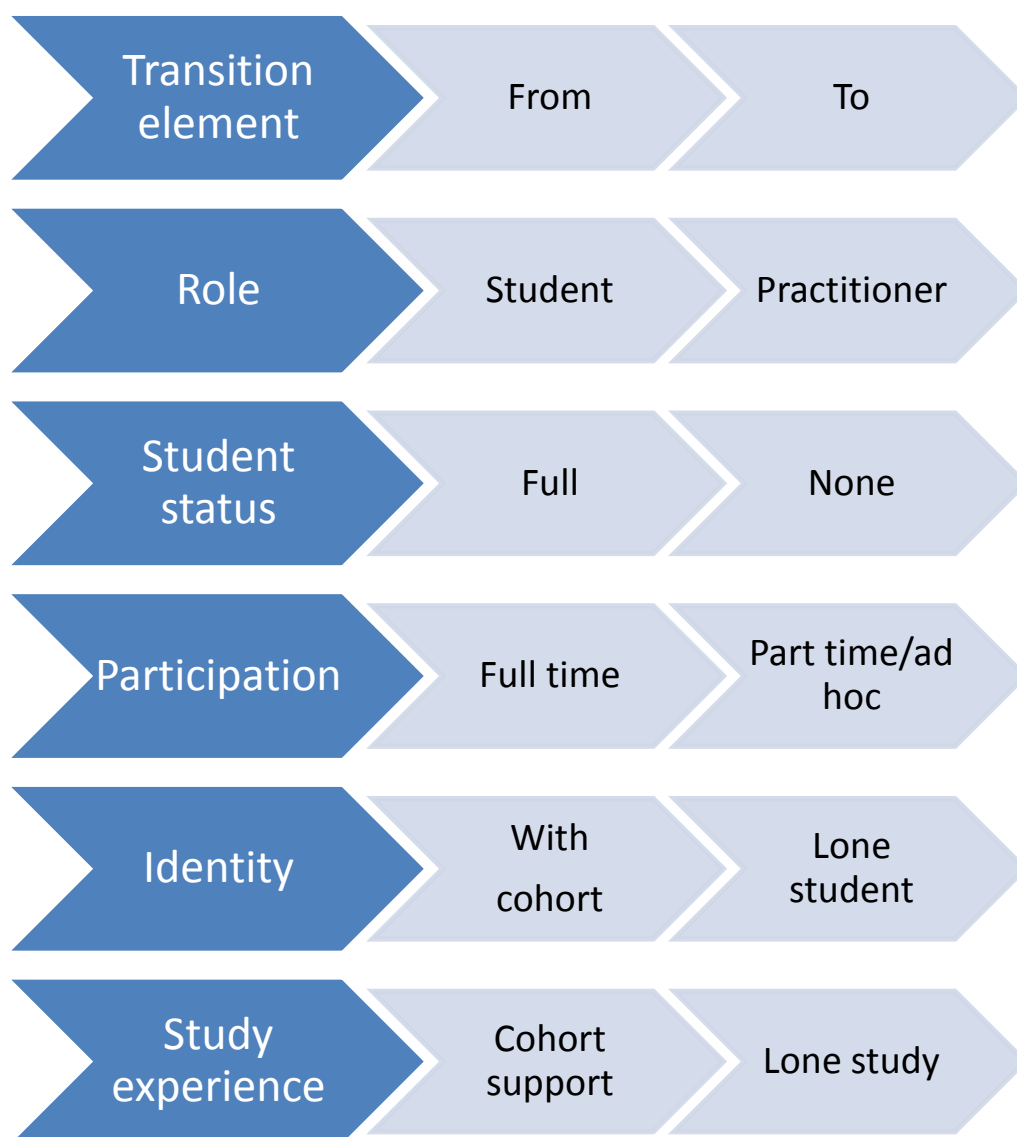


Figure 19: Product 3, Healthcare CPD transition model

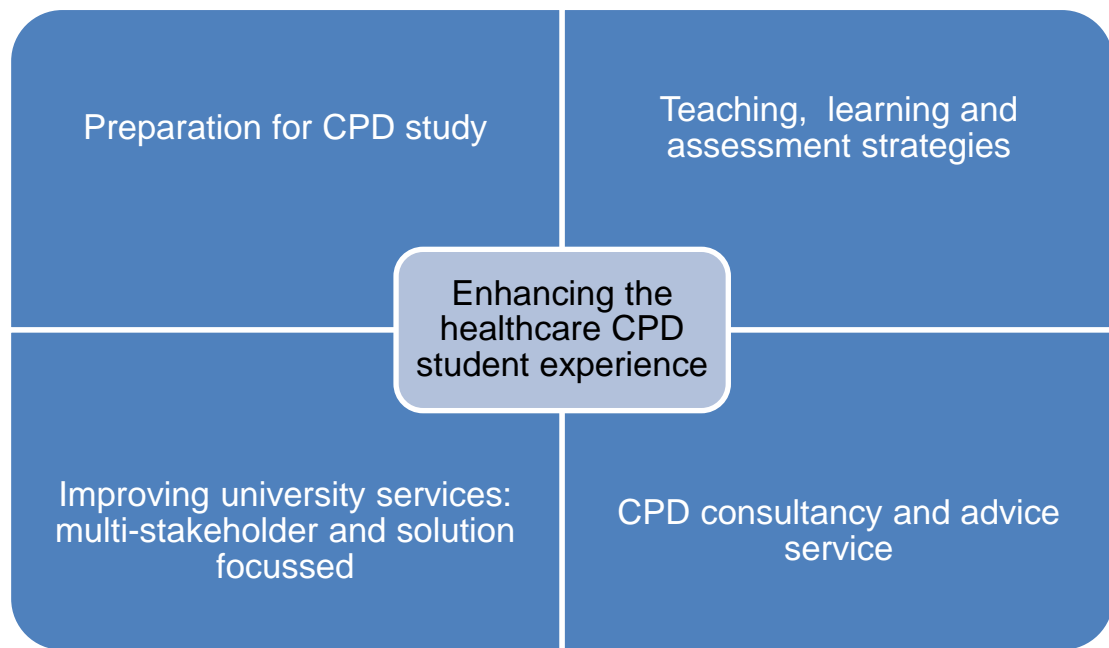


Figure 20: Four-point model for enhancing the healthcare CPD student experience

The model consists of four key elements reflecting different but complementary dimensions of the healthcare CPD student experience, each of which may stand alone. Recommendations within each element of the model are designed to address issues identified in the findings of the project. The model itself demonstrates the wide range of factors that may impact on the healthcare CPD student experience and the wide range of stakeholders who could be involved in enhancing that experience.

In the next section the elements and recommendations are discussed in more detail.

6.4 Recommendations for practice

Recommendation 1: Preparation for CPD study

The identification of strategies should be undertaken that prepare practitioners for the transition from the pre-registration study experience to the CPD study experience and that enable students to manage the reality of the CPD study experience.

Based on the findings from Dataset 5, there is evidence that students in this study experience a 'transition challenge'. The healthcare CPD transition model represents this transition from pre-registration healthcare student to healthcare CPD student.

Strategies could be adopted that draw on range of personnel within and beyond the University with relevant expertise and buy-in. This might involve University Learning Development Unit staff, the Students Union, healthcare CPD academics, healthcare CPD

students themselves and employers. The timing and format of preparation strategies requires consideration. It could form part of a preceptorship course, for example, and as such be directed at newly qualified nurses. It could take the form of a University-based stand-alone study day offered regularly throughout the academic year or it could be a component of healthcare CPD inductions. Given the nature of the CPD student experience, an online version should also be developed, perhaps in the form of a CPD study support guide.

Recommendation 2a. Teaching, learning and assessment: CPD student profiling

Healthcare CPD profiling exercises should take place at regular intervals so that at any one time we have a clear idea about the demographic make-up of our healthcare CPD students and changing trends in this student group, particularly in respect of funding sources.

Such data would enable healthcare academics to tailor curriculum planning and development to fit healthcare CPD student demographic and would enable University and School academic planning and approval committees to make judgments about the quality and 'fit' of proposed provision in the light of the healthcare CPD student demographic.

Recommendation 2b. Teaching, learning and assessment: Strategies

The formation of a community of practice (CoP) for healthcare academics engaged in healthcare CPD provision to share best practice in terms of teaching, learning and assessment strategies, which take into account the healthcare CPD student experience and which encourage joint employer/practitioner engagement.

Teaching and learning strategies should include those with a focus on blended learning, online learning and work-based learning.

The findings from this project indicate that, in relation to curriculum planning, development and provision, there is a requirement for a more explicit recognition of the CPD student experience in terms of timetable planning and access to learning resources, as well as more generally recognising and acknowledging the impact of multiple commitments, including working full-time, on the ability to study. In particular, there are key issues raised in this study about the lone student experience, the lack of cohort identity and its impact on the CPD student study experience. In terms of teaching and learning strategies, healthcare academics should be cognisant of the healthcare CPD student study experience and be encouraged to reflect on the extent to which current teaching and

learning strategies are designed to reduce the sense of isolation and encourage engagement and a sense of belonging.

A useful but not exclusive focus for such a CoP might be the use of the Garrison, Anderson and Archer Community of Inquiry Framework (Garrison et al., 2010), to assess the extent to which existing and proposed online and blended learning provision contributes to a positive learning experience and satisfaction for healthcare CPD students, based on social, teaching and cognitive presence. As part of the CoP, members might also share ideas and experiences based on the development of teaching and learning strategies that encourage joint employer/practitioner engagement in the teaching and learning process, can be seen to contribute to service development and impact positively on practice.

Whilst writing this project report I have been working with a small group of colleagues in the School on a pilot project with a remit to identify ways of enhancing assessment. A key focus of the work of the project group has been to identify strategies which develop assessment literacy in students. I have been able to share the findings from my project with the group and to discuss the challenges of enhancing assessment literacy in the healthcare CPD context. The focus of the healthcare academic community of practice discussed above should therefore also include assessment literacy and in doing so would become a forum for sharing ideas and best practice in assessment strategies for healthcare CPD students.

In Chapter 1 I discussed the ways in which nursing academics can play a part in enabling nurses undertaking CPD to develop their personal and social capital through engaging in teaching, practice and research. The teaching, learning and assessment strategy element of the four-point model for enhancing the healthcare CPD student experience, I believe, makes a modest contribution to the development of personal and social capital for nurses and nurse academics. The development of a CoP for nursing academics facilitates debate and analysis of the practice of healthcare education. It also enables nursing academics to work collaboratively to develop teaching, learning and assessment strategies meeting the needs of the CPD student in HE and to evaluate their effectiveness and impact using appropriate research approaches. Dissemination of research findings to a wider professional network opens up opportunities for collaborative external research. The CoP provides healthcare academics with openings to establish a network of academics with a self-defined professional identity in HE as externally validated academic experts in the *practice* of healthcare education.

Recommendation 3. Improving the University service experience

A multi-stakeholder, service improvement solution-focussed approach should be adopted in order to identify and improve aspects of University services that negatively impact on the healthcare CPD student experience.

Findings from both the stakeholder–curriculum and the student experience lines of enquiry indicated that there were aspects of University services that directly and negatively affect the healthcare CPD student experience at all stages of the student journey, from initial inquiry through completion and beyond. Work has already started. A multi-stakeholder group consisting of senior healthcare academics, Trust commissioners and University admissions managers has met to discuss strategies for improving healthcare CPD admissions processes and procedures. Each stakeholder discussed the challenges of the admissions system from his or her perspective, following which a joint action plan was agreed resulting in the production of a draft standard operating procedures document. Each stakeholder has commented on the draft and at the time of writing the final version is due to be circulated, signed off and implemented in time for the 2014/15 admissions cycle. Using the same multi-stakeholder approach, new procedures are in place to manage the administration of healthcare CPD study days. Currently under discussion is management of healthcare CPD student enrolments outside of the main University academic calendar induction weeks.

As with the findings related to employer engagement, I needed to think carefully about the negative light in which the University services were portrayed—again, if this perception was fed back to Trust employers, it could jeopardise the relationship between Trust and University and could result in changes to commissioning behaviour resulting in organisational harm from a reputational and financial viewpoint. However, the multi-stakeholder, service improvement, solution-focussed approach taken has reduced the risk of organisational harm and, indeed, has portrayed the University in a positive light in terms of being able to demonstrate that it understands the value that Trusts place in efficient University services.

Recommendation 4: A CPD consultancy and advice service

The development and implementation of a healthcare CPD consultancy and advice service designed to promote internal marketing, enhance external marketing and offer a value-added dimension to the Universities healthcare CPD offer to Trusts and to student self-funders.

Findings from the stakeholder–curriculum line of enquiry suggested that healthcare academics in general were not necessarily cognisant of the full extent of the healthcare CPD portfolio of provision and that there was a need for internal as well as external marketing of that provision. In addition, the politico-economic context for the whole of this study has been the on-going impact of the marketisation and deficit reduction strategies on Health Service provision and healthcare CPD funding. Essentially, HEIs and other CPD providers are competing for business from commissioners holding a reduced amount of CPD funding. At the same time, qualified nurses and midwives are still (and should be) required to demonstrate professional development through engagement with CPD in order to retain their professional registration and enhance their career prospects. As such, as an HEI, our CPD provision now and in the future is likely to be commissioned by NHS Trusts from a smaller funding envelope, and increasingly by self-funded individual practitioners.

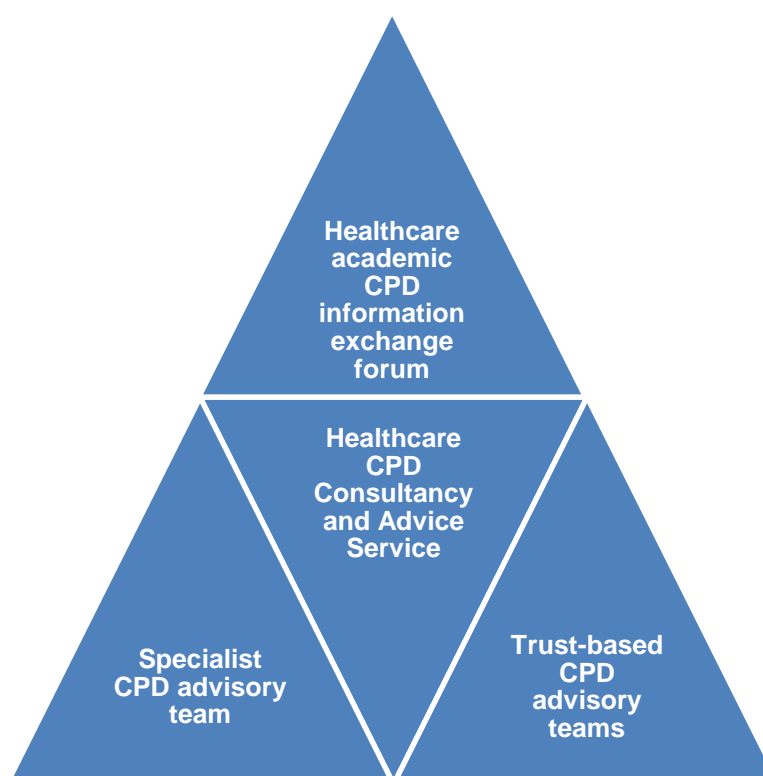


Figure 21: Middlesex University healthcare CPD consultancy and advice service

The service comprises three elements:

Healthcare academic CPD information exchange forum

Informed by findings from Datasets 1 and 5, forums for healthcare academics will take place throughout the year, with the first one being held early in the academic year following completion of the CPD commissioning cycle and final contract sign off. The aim

is that all healthcare academics and especially clinical link teachers have an overview of the how healthcare CPD is commissioned and purchased, what has been commissioned and by whom. The forum will provide staff with an opportunity to exchange ideas and opinions related to healthcare CPD provision. Regular feedback from advisors' Trust-based activities will be a key feature of the forum.

Specialist CPD advisory team

This team will consist of a group of healthcare staff, both academic and non-academic, who are available to offer a one-off or on-going information, advice and support service for healthcare practitioners who make enquiries about and require guidance on CPD activities. The team will also act as a source of information for employers and commissioners and for staff within the University who are involved in healthcare CPD administration such as Admissions and Finance. Initially consisting of Directors of Programmes and members of the NHS Commissioning and Compliance team, other members of staff with a specialist interest in CPD may wish to be part of the team.

Working with the University information technology and marketing staff, a dedicated CPD advisory team e-mail address will feature on every page of the Middlesex Healthcare CPD website. At the time of writing the dedicated e-mail address has been created and is due to be launched in July 2014.

Trust-based CPD advisory teams

It is envisaged that healthcare academic staff who link with clinical areas within Trusts and other healthcare placement providers, as a result of participating in the information exchange forums will be facilitated to expand their current clinical link remit. With the support of the specialist CPD advisory team and working with the Head of the Practice-based Learning Unit and her team, the new remit will include acting as CPD advisors to qualified staff, in addition to their existing mentor and pre-registration student support role.

Link teachers in the same Trust will be supported to form Trust-based advisory teams and to run regular Trust-based CPD events in conjunction with senior Trust staff with responsibility for workforce development. Partnership working was identified by Trust stakeholders as an important requirement of any CPD curriculum development work (findings from Dataset 1), as such partnership in workforce development will underpin the advisory team activities.

6.5 Recommendations for future research

Transition

I have argued in this study that there is a qualitative difference in the nature of the healthcare CPD student experience from that of the pre-registration nursing student experience in HE, and that this is captured through the concept of transition. Although there is published literature based on research into the transition experience and role adaptation for newly qualified nurses in clinical practice, more research is needed on transition in the context of the study experience in HE, particularly when lifelong learning and engagement in CPD is an on-going requirement for professional registration. This might take the form of a larger study involving CPD students from a range of professional groups including teaching, Social Work, Midwifery and Nursing.

Engagement

The results of the student experience study also indicate there is a difference in the nature of engagement with the University of healthcare CPD students from that of a full-time pre-registration nursing student. Students discussed not feeling like part of the University when undertaking CPD studies. For some students this was not problematic because, in contrast with their experience as pre-registration student nurses, their perception of self was derived from their identity as a healthcare practitioner rather than as a healthcare student. This warrants further study, which could take the form of a comparison of the nature of engagement with HE between the two groups, particularly when the pre-registration nurse education has a 50 per cent basis in practice-based learning that might in some ways mirror the CPD student experience. The concept of engagement with the University and student identity is an area of research that might also apply to other professional groups.

6.6 Final reflections, discussion and conclusion

The focus of this study was the healthcare CPD student experience of HE and their and other stakeholders' perception of what factors should be taken into account in the development and delivery of healthcare CPD. My original aim was to raise the profile of healthcare CPD at Middlesex on the basis of scoping work that suggested that the healthcare CPD student perspective was not accounted for in the policies, processes, procedures and regulations of the University. I argued that the healthcare CPD student experience was largely invisible. In addition, in the context of increasing marketisation of healthcare CPD, I argued that to retain and increase our position in the healthcare CPD

market as an organisation we needed to demonstrate that we value and actively seek our stakeholders' views, that we understand their needs and requirements and that this is reflected in the type of provision we offer.

I had hoped that as a result of this study there would be organisational transformation and change. This was not the case and I believe that this is probably the result of overambitious objectives. My vision that a CPD strategy based on the views of key stakeholders including academic staff would be embraced and actively utilised was misguided. As a result of implementing the stakeholder–curriculum line of enquiry, it became evident that perhaps one of the reasons why healthcare CPD academics have not necessarily developed and planned CPD provision informed by an overarching strategy is the long periods between validation and review. It is possible that staff members involved in and planning delivery might have moved. Politico-economic contexts may well have changed during that same period and the strategy may be perceived to be outdated and irrelevant.

There is also a challenge to academic autonomy. It may be that staff felt that their academic autonomy was being challenged through the imposition of a strategy. The change of name from 'Strategy' to 'Principles Document' was perhaps made in response to this. It was also perhaps unrealistic to expect full-scale unchallenged acceptance and immediate implementation. I realise that encouraging change on this scale is a slow-burn activity that may require a 'hearts and minds' culture shift. It may also require the principles to be applied to day-to-day curriculum changes and to be re-enforced by scrutiny committees. Evidence of value by external stakeholders may also encourage staff. Perhaps what is needed is for stakeholders to convey the message that the reason that Trusts commission from us is because of what we offer in terms of CPD provision, the fact that we operate from the perspective of valuing stakeholder opinion and, reflecting that, how we deliver and what we deliver in terms of healthcare CPD provision. Feedback on our offer from stakeholders is therefore essential and the messages must be conveyed to healthcare CPD academic staff. This may happen in several ways: through the COI, and through the teaching, learning and assessment, and through the CPD consultancy and advice elements of the four-point model for enhancing the student experience. Here, as advisors, academic staff will be actively engaging with Trust staff and as such gain an increased understanding of CPD student need. Professional forums will act as an opportunity to share information and ideas with colleagues.

In respect of the healthcare CPD student experience study, my hope that organisation transformation would take place was again unrealistic. I believe, however, that I have

achieved my study objective of raising the profile of the CPD student in the University. Discussion and dissemination of findings from this study have resulted in raised awareness at organisational level of the needs of the healthcare CPD student. I now represent the CPD student perspective on a variety of University-level groups—induction, implementation of the new VLE, grading and classification, attendance monitoring and at a one-off meeting to discuss part-time postgraduate students' needs and requirements.

Looking at the results of this project in a holistic way, I realise that what I hoped to achieve should be seen in the context of a long game. It is evolutionary rather than revolutionary change. Rather than contributing to wholesale organisational transformation, what I have achieved is a slow-burn heightened organisational awareness whereby senior staff in key areas of the University recognise that there is a healthcare CPD perspective that should be taken into account.

Wan (2013) suggests that organisational change and organisational transformation are different, and that organisational transformation is a specific type of change.

Organisational transformation results in paradigm shifts, is radical rather than incremental and transitional, and results in redefinitions of organisational beliefs, attitudes, values and purpose. It is a complex, non-linear process. Ginsberg and Bernstein (2011) discuss organisational culture in the context of transformation and argue that, in order to facilitate transformation, shifts in shared perceptions, thoughts and beliefs are needed. They suggest that when the organisation is in a stable state new views are less likely to be accepted. Marshall (2010) contrasts process and systems change, which he argues is generally driven by small groups or individuals (interoperable change) with structural and organisational changes associated with organisational instability (discontinuous change).

Reflecting on aims and objectives and outcome of this study, I can see that it is possible to locate it within Marshall's definition of change, that is, one which is driven by an individual. The power of the individual to effect change may be somewhat limited.

Ginsberg and Bernstein emphasise the role of the leader, suggesting that change is more likely to take place when the leader demonstrates the value of the change to the organisation's members through allocation of resources or a statement in support of the change. They propose a three-actor model, where three types of person are required to effect change. Ginsberg and Bernstein (2011: 4) suggest that in addition to the leader, who has institutional power and influence to effect change, the role of 'change agent' is of paramount importance. The change agent 'possesses passion and on the ground substantive knowledge to help make change occur'. Finally, they suggest, there needs to be a facilitator—someone with a degree of organisational power along with 'on the ground'

knowledge. In their discussion of organisational culture change they identify the Associate Provost as the leader, faculty members as the change agents and the Director of the Faculty as facilitator.

This was a helpful model in the sense that it helped me to see this project as part of a broader two-stage process and systems change (not a transformation) which, to be effective, requires the intervention of a change agent, a facilitator and a leader. Stage one in the process is in progress. I have proposed a series of actions through the four-point enhancing the healthcare CPD student experience model to be implemented at School level. I believe that the actions need to be implemented, evaluated and reported. If the outcomes are positive these should be disseminated internally and externally. A key recipient of the outcomes report is of course the leader, who has the power to effect change. A report to the leader of positive outcomes serves as evidence for change.

Organisationally, the Institute of Nursing, Midwifery and Social Work incorporates two departments within the School of Health and Education. The changes proposed in the four-point model will take place wholly within the Institute. In this context the key actors might be the Dean of the School as leader; the Head of the Institute as facilitator and myself as change agent. Each of these roles is significant in that we all have internal and external facing roles. We therefore have the opportunity to 'sell' the change both internally and externally to key stakeholders.

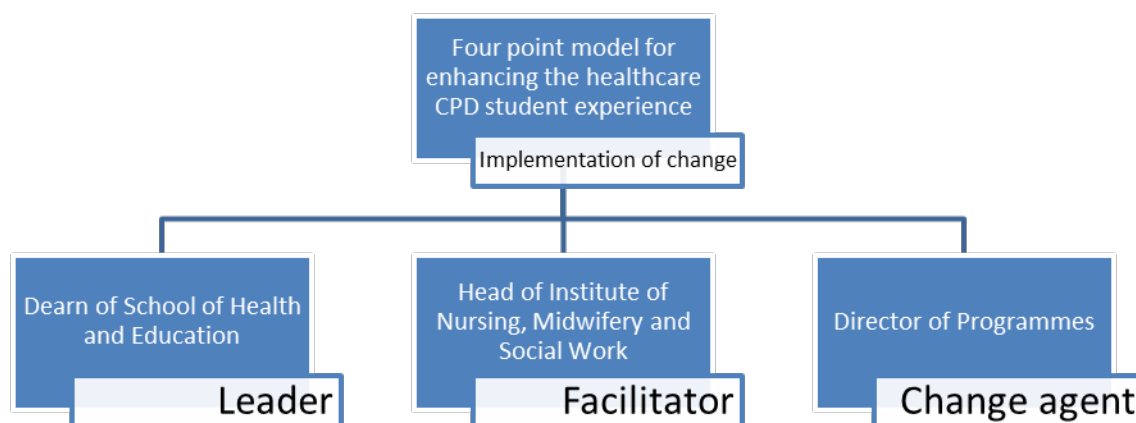


Figure 22: Key actors in the healthcare CPD student experience project

Any change has to be continually revisited, encouraged, re-enforced, evaluated and reviewed if it is to be sustained following implementation. It is my hope that the successful implementation of the four-point model, along with positive feedback from key stakeholders on the four elements within the model, may contribute to the 'hearts and minds' change discussed above. In many ways, therefore, this is the start of another

transition that includes encouraging a new perspective among healthcare academic and administrative staff. In this view, strategies for enhancing the healthcare CPD student experience are owned by the collective 'us' rather than the single individual 'me', and 'we' become the change agents.

In this context I envisage the Dean of the School as a key actor at University level. In this iteration of the model the Dean acts as facilitator; the Head of the Institute, CPD healthcare academics and I are change agents; and the leader could be the Director of Student Experience. It is at this second stage in the change process that there is the potential to move from organisational awareness to organisational change, particularly if the experiences of healthcare CPD students in HE can be shown to map across to other professional groups.

Gradual change is not immediately discernable. It may be that the full extent of the changes discussed above will only be visible from the perspective of distance. Given what I have discussed about the impact of politic-economic changes, it is possible that healthcare CPD education provision may undergo further change both in terms of type of provision and possibly location. This does not make the results of this study redundant, as they can be transferred to other CPD contexts, for example teaching and Social Work. Raising awareness of the healthcare CPD student will, I hope, raise the awareness of the needs of any group of students who do not fit the three-year, full-time undergraduate 18 to 21-year-old mould.

Chapter 7 Critical Commentary: Reflections on learning and professional development

7.0 Introduction

In reflecting on who I was at the start of my doctoral studies, many years ago, and reviewing my learning in attempting to demonstrate that I possessed the skills, knowledge, authority and capability to study at doctoral level, what is striking is how much I have changed, whilst at the same time how little. This reflective commentary focusses on learning and changes that have occurred during the course of this project.

My review of learning draws on my personal and family experiences and how these have impacted on my attitude towards education and subsequent choice of career. I am still fired by the need to aim for A*, still irritated by occupational hierarchy, still passionate about fairness and justice, and despising discrimination. My reflections on why I chose to focus on the healthcare CPD student experience links with the values and beliefs that guide my personal and professional life and the work referred to in my review of learning. The notions of fairness, equality of opportunity and equality of access are important to me, possibly or even probably because of my own experiences as a Black British woman in education and in the world of work. I still feel very strongly about any system that directly or indirectly ignores the needs of a person or group of people, which in turn may impact on their ability to get the most from that system.

My review of learning also focusses on professional learning and identifies what I saw then as a recurring theme throughout my professional life; that is, taking the safe option and therefore being confident of success in educational and career terms. I can in all honesty say that the journey through my doctorate from start to finish was the complete antithesis of this—this was not a safe option, nor was it risk free, although regarding confidence it is possible to map where on my professional learning journey that confidence—initially low— started to build.

I initially gained approval to start a project on a completely different aspect of health curriculum leadership and spent three years looking at factors associated with attrition from pre-registration nursing. At the time I had good reasons for wanting to explore this and it was a project that nurse directors from our partner Trusts were keen to see completed. The decision to change the focus of my project symbolises one of the themes that I have identified that contributed to personal and professional learning. I wrote after discussing my decision to change project with both my professional and academic

supervisors that: 'my project started out being determined by others, usurped by events—feeling of time lost and time wasted—possibly...'.

Being usurped by events felt like a constant threat throughout the course of this project and has not receded, even as I approach the point of completion. I mention elsewhere in my reflective notes that it felt like constantly shifting political and economic sands—not least being the change of government in 2010 and subsequent changes in health and education policy. I referred to this as the increasing marketisation of health and healthcare education. Sands were seemingly constantly shifting (and still are) inside the University, too. Some of these shifts had a significant impact on my professional practice. It is fair to say that, without the 2007 academic restructure and establishment of the role of DoP, I would not have been able to focus on healthcare continuing professional development in quite the same way. At the time, I thought that I 'probably would have dropped the Doc if the position of DoP had not been open to apply for'.

A key realisation as a result of my role as a DoP, reflecting on the status of healthcare CPD within the University, was the need for a better understanding of the healthcare CPD student experience as part of the wider University focus on the student experience and in comparison with other students at the University. This was the catalyst for the project.

7.1 Living with uncertainty

In the early stages of my professional journey I recognised my risk-averse tendencies. I commented on this in my review of learning. In that review I suggested that my developing experience gave me the confidence to take risks, particularly with students. I referred to a classroom session on a controversial women's health issue: 'I feel free to leave the problem unsolved and to suggest that we have to live with the untidiness of some aspects of life'.

Living with untidiness came to characterise my project journey, particularly in the early stages. I found that although I thought I understood untidiness in the context of teaching, I found it very difficult indeed to live with when engaged in project work. Carrying out the project felt like a completing a series of separate activities that had faint dotted-line connections to each other, despite the fact that the overarching aim of the project was to explore the experience of the healthcare CPD student. This was compounded by the changing politico-economic context, which added another layer or dimension of, if not untidiness, then definitely uncertainty.

Progress through the project did not feel linear. At times, the picture was clear and I felt confident in the progress I was making and the knowledge uncovered, then the picture I was building up of the CPD student experience would cloud over or become partially obscured with alternatives. For example, was I regarding a picture of a healthcare CPD student in HE or of a part-time student?

I had clear/opaque experiences in relation to the Curriculum Principles Document. I was absolutely clear about the need for a CDS, but quite unsure about the research approach taken. This is reflected in my discussions in earlier chapters about whether the project constituted AR, which I will revisit this later in this chapter. Similarly, I was clear about the value of the CDS project but uncertain about how it would be received by colleagues. Again, this will be discussed in more detail below.

The most significant aspect of the clear–opaque dynamic was in the context of the insider worker–researcher. I had a clear intentions of getting on with the project but a real sense of frustration about progress, or lack of it, with the project, clouded by the demands of the job. In my reflective notes I discuss the sense of ‘time passing, doing ethics form and project paperwork... all good’, but ‘so busy’ doing the job.

7.2 Personal learning: Perceptions of self

From the start of the project I operated as two separate selves; self as worker—good at what I did and doing it well; and self as doctoral student—sometimes making progress and at other times progress stalled. When this happened it was so easy to slip back into worker mode and to use the business of the job as a rationale for not making progress. I adopted this position through the majority of the stakeholder–curriculum line of enquiry.

A significant change in my perception of self took place as the project progressed. I started the questionnaire and focus group aspects of the project with two frames of reference: self as worker/doctoral student, and self as insider with my students as outsiders with few shared experiences. I had not in any way associated my experience as a doctoral student with the study experience of the healthcare CPD student. However, having listened to their stories and read what they had written about the student experience, there was an emerging realisation of a shared experience. The issues of time pressures, multiple commitments and the lonely student really resonated with me and I found myself thinking, ‘your experience mirrors my experience’ and empathising with them in terms of this shared experience. I felt that this gave me a better understanding of my own student experience and validated some of my feelings about the duration of my

project work. For me the shift in perception and the association and connection with the student experience was particularly significant. This was definitely a 'light bulb moment' of significant impact on my personal learning. However, I am pleased that this realisation occurred after the data collection phase was complete. Wilkinson and Kitinger (2013) discuss the dangers of adopting an insider approach when the researcher uses an experience common to both researcher and participant. One approach that they discuss is where the researcher joins the group and becomes a participant. Data from the researcher/participant is incorporated into the research. Wilkinson and Kitinger suggest that, although this strategy may appear egalitarian, in situations like this the researcher in fact 'gets to make a double contribution to the project as researcher and researcher' (Wilkinson and Kitinger 2013: 254). The inclusion of a section about the impact of this project is therefore very much about how this affected my perception of and learning about myself. It should be seen as separate from the main findings, which are wholly concerned with the experience of CPD student. That said, I have found myself drawing on my 'student' status in my teaching—particularly with dissertation students. I think I am a better teacher now and I understand their experiences better as a result of conducting this study. At the start of this project I slipped in and out of student mode—more out than in—using work as an excuse for lack of progress. When in student mode, at times I was frozen with uncertainty, at other times procrastinating, self-doubting and as result intermittently productive. The project has given me an insight into self that I had not fully recognised.

New insights into my own professional development can be seen through my final jottings in my reflective notes, referring to ways in which I might be able to implement strategies to manage the transition from full-time student to CPD studies:

- End of year session in college
- Speak to Trusts—XXX and YYY
- Add to transition into preceptorship programme
- Speak to Cottrell
- Write booklet.

The final two entries demonstrate the growth in confidence in my professional abilities. I would never previously have considered contacting Stella Cottrell, an acknowledged expert in the field of study skills, critical thinking and professional development.

7.3 Personal learning: Influencing others

A key concern in this study was the impact on the stakeholder/HEI relationship, should the findings from the study show any of the stakeholders in a negative light. This was particularly important in relation to Trust commissioners and students, as they can vote with their feet and result in a smaller CPD contract and less income for the University along with a possible loss of reputation. The impact presented a dilemma for me as the person responsible for uncovering or highlighting the problematic issue and what it might mean for colleagues delivering healthcare CPD provision, with whom I worked on a day-to-day basis. It was also perfectly possible that, in either line of enquiry, academics might have been criticised either in terms of their teaching and learning strategies or in terms of student support. Taking 'the University' as a separate entity to 'the academics', it was both possible and, based on my experience as a DoP, likely that the University might have been negatively perceived by students, in particular. My assumption, however, was that the University as a learning organisation might welcome feedback from a group of students from whom it had not hitherto gathered information. Their experiences would, if fed into activities aimed at improving the student experience, demonstrate that the University recognised the diverse nature and needs of the student body.

In terms of the other key stakeholders it was important to recognise the power dynamic between stakeholders. Commissioners (funded by the SHA) and students as self-funders were, I believed, the most powerful actors in the stakeholder-university dynamic in the sense that if their perception was that the University did not provide value, one response might be to purchase healthcare CPD provision elsewhere. There was a similar risk if the results of the study showed other key stakeholders in a negative light. I considered the strength of the existing stakeholder/HEI relationship and, based on my perception, I decided that it was robust enough to withstand any negativity arising from the study. Indeed, like the University, Commissioners and Trusts might view the study as an opportunity to improve aspects of their CPD-related activity.

However, I was less sure about the possible responses from academic colleagues. I anticipated that academic practice, if identified as an issue, would be more difficult to challenge. I decided that focussing on learning from the research and the joint identification of strategies that could be seen to impact positively on individual as well as team development, in relation to academic practice, might mitigate against any potential persistent negativity.

I was right about the risks of challenging academic practice. In my reflective notes I wrote about presenting the results of the stakeholder–curriculum study to academic staff colleagues and receiving a ‘less than enthusiastic’ response, in contrast to the keen and enthusiastic response I received from students and PQSG. I noted that I was ‘learning about resistance’, something that I had commented on during the interview with Jane. The decision to produce a webfolio later that year was in response to this. By embedding the CPD and Staff Guide in an online resource for staff that included a range of other CPD relevant resources, I produced a resource of practical use to colleagues. The webfolio was an unintended outcome of the project. At the time I saw it as a detour from the main project, but a necessary diversion. It required me to consult key e-learning staff about the best approach, then to learn a new set of skills in order to develop the webfolio. I wrote: ‘felt ridiculously proud of myself—doing PebblePad. Testing my attention to detail and the need to check and re-check everything. It looks good’. I presented the finished product at a Departmental ‘away day’ and to PQSG, where it received a much more enthusiastic response.

My concerns about the ability to influence were heightened by findings from the student experience line of enquiry. My reflections on completion of this part of the study are best described as emerging insights and were encapsulated in an interim reflective paper written for my professional advisor. In it I suggest that the ‘absence of a coherent curriculum strategy and a lack of understanding of the nature of the healthcare CPD student experience’ was one reason why our healthcare CPD offer did not necessarily meet the needs of our stakeholders. In addition:

Frequent organisational change between 2007 to date may also have contributed: implementation of Learning Framework, academic staff restructure, E assessment, more academic staff re-structures, campus moves, voluntary redundancies, changes in the number and structure of Schools and currently the ‘new direction’ for the University. Combined with external changes in government and fundamental changes in health and education policy it is possible to see how staff have had to work in a constantly changing context where the safest approach to work is head down and keep doing what you are doing.

What was not needed was one of your colleagues presenting the results of research work indicating a degree of dissatisfaction with our CPD offer. I argued that the gaps in our healthcare CPD ‘offer’ related in part to the CPD needs of our own nursing and midwifery academics. The majority are registered teachers with a PGCE. But these qualifications are in a sense generic, in that they do not (and probably cannot) reflect the variations in the types of students that staff are likely to teach. These are pre-registration, post-registration, full-time, part-time, with associated variations in the student experience. I summarised that University staff development activities were also generic by nature. In

addition, the 'silo' approach to healthcare curriculum development within the School was a contributory factor. I can see that for some colleagues the findings from this project constituted a threat to their autonomy and right to practice in a particular way. This might have accounted for some of their resistance. Having completed a significant amount of the study, however, gave me confidence to engage in debate and, where appropriate, to challenge. My arguments were based on knowledge and evidence that gave me real sense of empowerment and the feeling that I now had the authority to make judgments about the student experience based not only on experience but on evidence, crucially derived from the students' perspective.

In my interim paper I suggested that one of the possible outcomes of the project, based on findings at that time, was to:

develop and lead the implementation of communities of practice for healthcare CPD teachers, using the resource portfolio as the central communication point for discussion and to submit and share information.

This recommendation is now embedded in wider four-point model for enhancing the healthcare student experience. On reflection I am pleased that I did not pursue this recommendation in isolation. The findings from the focus group were key to developing a more in-depth understanding of the student experience and enabled me to generate a student experience enhancement model where staff development was an important, but not the sole element.

I have discussed the relevance and importance of the stakeholder–curriculum line of enquiry in the main project report, the resulting Curriculum Principles Document and the Staff Guide based on the contributions of key stakeholders. Despite my view that that implementation of both cycles of this line of enquiry was successful, towards the end of Cycle 1 I started to have doubts about the project and the doctorate in general. This occurred after my failure to be selected as a University Teaching Fellow. I recall being devastated and calling into question not only my competence as a teacher but my right to be undertaking a doctorate. I wondered about others' perception of me and whether this in turn would negatively impact on my ability to influence others. It took some time to gain some perspective on this and to see that this professional (and very personal) set-back did not seem to be having had any obvious effect on my relationships with key stakeholders outside the University, although I was still aware of my role as an insider worker–researcher and wondered whether being a 'failed teaching fellow' would influence colleagues.

My second attempt at applying for a Teaching Fellowship, in April 2012, was successful and had a significant impact on my confidence, not least because as part of the application I had included a section on how my doctoral studies contributed to my personal and professional development, and could potentially contribute to organisational development. It was at a meeting with the University DVC where the value of the work I was engaged in was discussed and hope expressed that the outputs might in the future be applied to other students undertaking CPD studies at Middlesex.

7.4 Recognition of ability to influence

In addition to the interim paper referred to above I felt confident enough to send an interim report to the Director of Student Experience (DoSE) based on the simple statistical data and the analysis of the free text narratives. What is interesting to me on reviewing the report is that, although the core issues that I raised were relevant, after the passage of time re-analysis of the focus group data and engagement with the literature enabled me to move from a simple to a more complex way of thinking about the experience underpinned by the concept of transition. That said, I think sending the report to the DoSE was significant in terms of recognition of influence and authority by others in the wider University. The 'cracked record' feeling that I described in the early chapters of this report was still there, but I felt it was now supported by evidence. In March 2013 I gave a presentation on the CPD student experience at the launch of the Middlesex University Institute of Nursing, Midwifery and Social Work. Later that year, in May, I was invited by the DoSE to be a member of the University Induction Group. In September the DoSE contacted me again, this time to discuss the postgraduate part-time student experience:

I've been given your names as those to approach for a small informal meeting to help me to gather some insight into the postgraduate student experience—particularly part-time.... Instead, might it be possible to gather at the start of September to talk through your take on the experience of your students?

Finally, in December I was asked to provide a CPD perspective of student needs so that these were taken into account in the introduction to the University's new VLE.

The Head of E-Learning wrote to me, asking me to meet:

colleagues from CCSS to discuss your requirements and how as an institution we can get these student who sit outside the current academic structure recorded in MISIS and as a result given access to other resources such as Moodle and the library etc.

A second e-mail followed:

If you could spare an hour to meet with [REDACTED] it would be greatly appreciated and would go a long way to help us in gaining an understanding of the University's requirements for better supporting CPD.

Looking back on 2013, I am sure that the invitations I received to participate in work at University level were the result of sharing my project findings formally and informally in the University, and was a recognition by others of experience backed by evidence. I feel justified in stating that I achieved one of the aims of the project—to raise the CPD student profile in the wider University, although not necessarily in the ways I anticipated. The changes that may be seen within the University in relation to healthcare CPD represent organisational awareness and slow process transformation rather than wholesale organisational change. Since then I have been successful in securing research funding to run a pilot study on the impact of CPD on practice as a direct result of the findings of the project. I am also supporting others engaged in developing e-learning materials for CPD modules and have presented my work at an RCN conference in Harrogate in February 2014, and will be presenting again at the Nurse Education Today Conference in Cambridge in September 2014 .

7.5 Work-based research: Learning through practice

Chapter 3 of this research report contains a discussion about uncertainty relating to the research approach for student experience line of enquiry. This was a significant learning journey, at times genuinely anxiety-provoking in the sense that as far as I could see my research approach did not 'fit ' any of those I had read about in the research literature. I remember the excitement of starting to read about mixed methods research and then the disappointment of discovering that true mixed methods research had to involve approaches located in the positivist and interpretative paradigms.

The decision to describe my project in my own terms as 'a naturalistic, qualitative study with a co-operative focus constituting two lines of enquiry, using within-method triangulation' symbolises professional development and learning. To return to the issue of being risk averse, it was one of the greatest risks I took during the project. I felt as though I had almost invented my own research approach as a result of developing research knowledge throughout the project. This is knowledge that I applied to and grounded in workplace research practice. In essence, what I feel I have done is to apply purist research principles to a real world, real life, workplace context and practice. This is something I should never have been able to do at the start of this journey and is, for me, evidence of my own personal and professional development as a result of completing this project.

7.6 Concluding comments

In Chapter 3 I offered a model demonstrating three elements that, combined, contributed to the process of self-study of professional practice. This chapter has drawn on all three elements and has enabled me to demonstrate how my professional practice has developed as a result of completing this project. It shows how this has impacted on my work as a DoP and my contribution to the wider organisation.

Is there anything I would have done differently? I do wish it had not taken me so long to complete my doctoral studies, but my initial false start and need to change the focus of the study was a positive outcome insofar as I was able to study in depth an issue about which I was passionate. There were times where I despaired of the different elements of the project ever coming together, but I am pleased with the final result. The implementation plans based on my recommendations are already in place; not before time, as the sands of healthcare CPD education are about to shift yet again.

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Appendix 1: Ethics submission



SCHOOL OF HEALTH AND SOCIAL SCIENCES

Dympna Crowley,
Chair, Health Studies Ethics sub-Committee
HSSc

13th January 2011

Dear Dympna,

Please find attached four separate Ethics committee submissions which relate to my D. Prof. project. These are:

- Participant information sheet—student questionnaire
- Participant information sheet—administrative staff questionnaire
- Participant information sheet and consent form—student focus group
- Participant information sheet and consent form—interview Middlesex University Student Union Officer

As part of the project I will also be using existing forums and meetings to discuss the two elements of the project: enhancing the post-qualifying healthcare CPD student experience and developing a strategy for post-qualifying/postgraduate healthcare provision. The forums and meetings include: the Professional Forum (Nursing and Midwifery Academic Staff); Post-Qualifying Steering Group and routine meetings with Associate Deans (Business, Academic Development, Learning and Quality Enhancement).

I have spoken to my supervisor about this and she is of the view that as key elements of the project form part of my day-to-day work as a Director of Programmes for Post-qualifying Nursing and that the forums/meetings take place as routine part of the School's

work, it may not be necessary to obtain formal **written** consent or to provide a participant information sheet.

I intend to include the two elements of the project as agenda items and, at the meetings/forums, ensure that the item is preceded by a clear verbal statement about how the feedback from the meeting will be used i.e. being collected as part of my DProf project which relates to enhancing the post-qualifying healthcare CPD student experience and developing a strategy for post-qualifying/postgraduate healthcare provision. The forums/meetings will be minuted so there will be a written record of the fact that information about the project was given as well as a record of the discussions which took place.

I would be grateful if the Ethics Committee would consider this proposal.

Yours sincerely,

Venetia Brown

Director of Programmes for Post-qualifying Nursing

&

DProf Student

Appendix 2: Ethics approval



**Middlesex
University**

School of Health and
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The Archway Campus
Furnival Building
10 Highgate Hill
LONDON N19 5LW

Tel: +44 (0)20 8411 5000

www.mdx.ac.uk

To: Venetia Brown
DProf

Date: 18th April 2011

Dear Venetia

Re: Venetia Brown, Application (724)—‘The experience of post-qualifying health care students of university-based continuing professional development (CPD)’. Category A2 & A3. Supervisor Kay Caldwell

Thank you for the response which adequately answers the ethics committee's queries. On behalf of the Health Studies Ethics sub-Committee, I am pleased to give your project its final approval. Please note that the Committee must be informed if any changes in the protocol need to be made at any stage.

I wish you all the very best with your project.

Yours sincerely

Ms Dympna Crowley

Chair of Ethics Sub-Committee (Health Studies)

Appendix 3: Draft strategy feedback

PQ/PG provision: draft strategy feedback from stakeholders

Trusts/Provider Organisations criteria to inform PG/PQ education development and provision—first draft Venetia Brown

PQ/PG provision should be:

- Relevant
- VFM
- Change /improvement in practice
- Contribute to service/Trust objectives
- Flexibility
- WBL
- On site/local

Practice Teacher (PT) added

- Quality
- Inter-professional
- Progression => staff retention
- Piecemeal?
- Part-time modules/students
- Short
- Quality reviewed/monitored

Academic staff added...

- Multi-disciplinary
- Online learning (distance learning)
- Proven expertise (academics need to market themselves)
- Skills networks as from 2012
- Foundation Trusts (more autonomous, enhanced status)

- Service users—stakeholder group added by academics
- Education which makes a difference and is fit for purpose
- Importance of diversity, confidence and communication (proficiency in English)

Trusts/commissioners added...

- Credibility of the University is important
- Good standards of qualification

SHA added...

SHA criteria to inform PG/PQ education development and provision—first draft VB

PQ/PG provision should be/demonstrate:

- VFM—relevance, enabled to do job better. Less concerned about credit/award?
- Inter-professional focus
- Partnership working with Trusts at all stages
- Quality reviewed/monitored

Academic staff added...

- Project work, bespoke

Note: annual monitoring CPIs indicate what is important to SHAs

PTs did not add to this section

Trusts/commissioners did not explicitly comment re this

SHA added...

University criteria to inform PG/PQ education development and provision—first draft VB

PQ/PG provision should be/should demonstrate:

- Cost effective, critical mass, viable
- Preferred provider
- Tested in terms of on-going sustainability or sufficient demand for new provision
- Progression opportunities
- Compliment to BCI provision including non-credit bearing study days
- Flexibility
- Rapid response
- Inter-professional

PTs added....

- flexibility in terms of days, evenings, weekends
- short

Academics added....

- Internationalisation
- Student Experience - positive
- Pro-activity

Trusts /Commissioners added....

- Responsive to University demands (note possible conflict between Uni exec and academic staff)
- Credibility/status 'out there'
- Strategies which result in benefits of bring people together are evident

SHA added...

Students' criteria to inform PG/PQ education development and provision—first draft VB

PQ/PG provision should be should demonstrate:

- Affordable
- Relevant
- Work/life balance
- Awareness of IT access issues
- Short
- Lead to a qualification (academic or professional)
- On University site/away from work place but prefer not to travel far

PTs added...

- Short—but depends on module content
- Tutor support—pastoral and academic may affect decision about where to study
- Realistic in terms of hours needed for study
- Awareness of non-contact time/add module learning time
- Link to career development
- Step on and off but still collect credits

Academic staff added...

- Clinical relevance
- Efficient induction (not whole day)
- Comparability (with other HEIs—one person remarked that other HEIs tend to have more 15 or 20 credit modules)

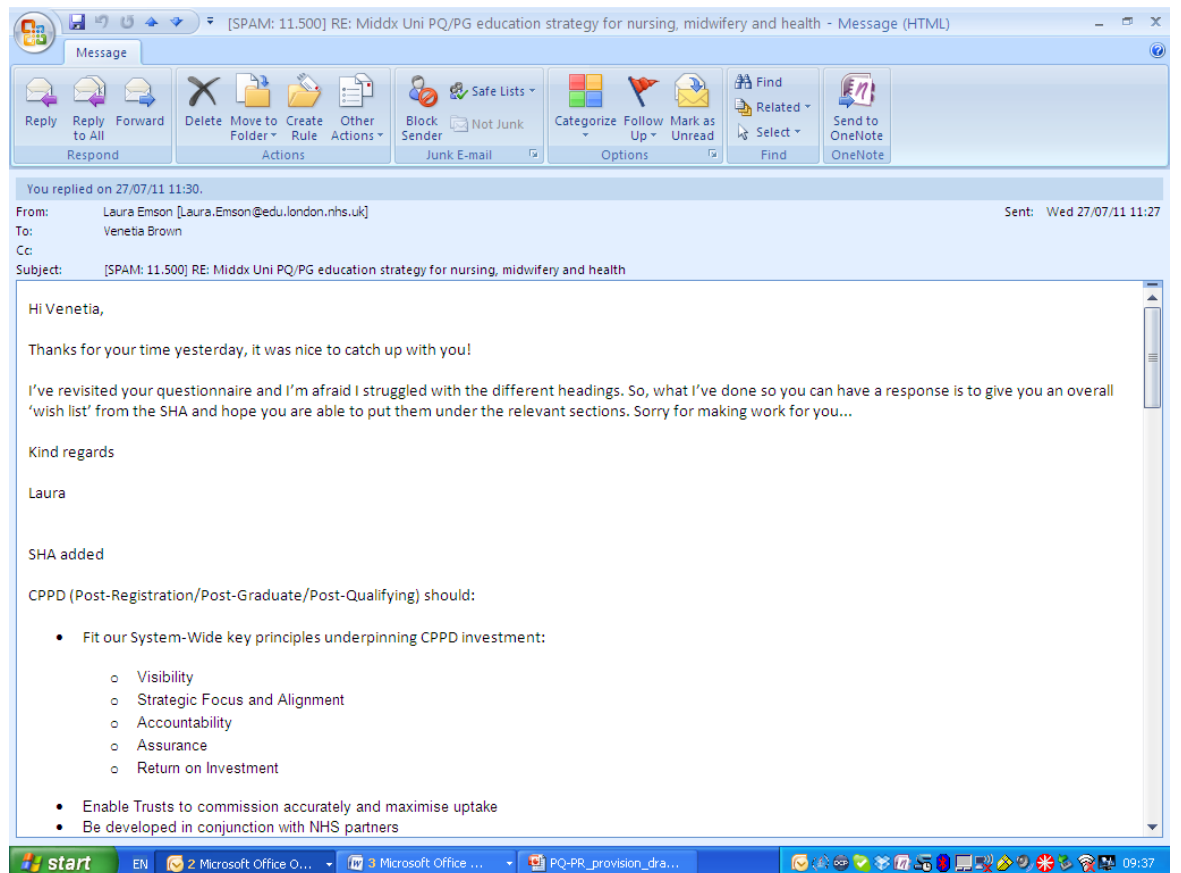
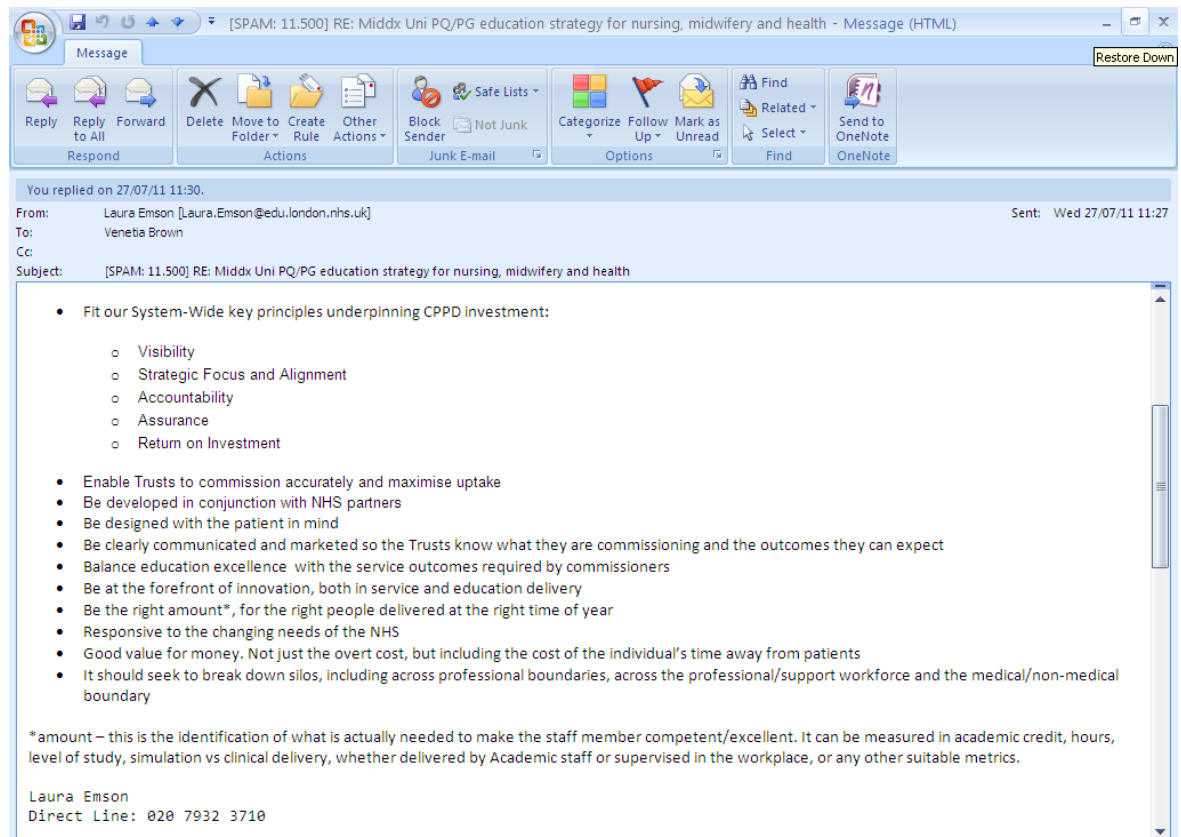
Trusts /Commissioners added...

- Good location for facilities
- Travel
- Discounts
- Pastoral care

- Support
- Equality
- Career development—immediate enhancement
- Employability
- Messages re existing and new provision 'out there'.

SHA added...

Appendix 4: Professional conversations with SHA



Appendix 5: Access arrangements

Hi Venetia

I think it would be fine to ask the mentorship students. Does it make sense to ask the students on maybe Day 4 or 5. Not day 6 as too much other areas to be covered. I have attached the timetable which will help with dates etc

Regards

Nora

-----Original Message-----

From: Venetia Brown

Sent: 26 August 2011 10:13

To: Janet Holmshaw; Clare Maher; Chris Bewley; Theresa Bourne; Stephanie Michaelides; Kate Brown; Marion Taylor; Nora Cooper; Jennie Bradford

Cc: Kay Caldwell

Subject: D Prof data collection: CPD student experience

Dear all,

I have slowly but surely got to the data collection stage of my DProf. I now need to send questionnaires to a range of CPD students to canvas their opinion on improving the CPD/part-time student experience. In the table attached I have identified the student groups I would like to survey. To get a broad range of opinion I have identified the following groups:

Students taking a stand-alone module in MWY, MHR, NSA & PHC at UG level

Students taking a stand-alone module at PG level in MWY, MHR, NSA & PHC

Students taking a long programme/award in MWY, MHR & Nursing at UG level

Students taking a long programme/award in MWY, MHR & Nursing at PG level

Can you please have a look at the table attached and let me know if the groups I have suggested are feasible/sensible and if not suggest an alternative. You will see that there is space to comment in the table.

I also need to ask your permission to access your student groups please. Finally I need to know when, during the module I might be able to come and talk to your group and administer the questionnaire.

You should also be aware that I have School Ethics Committee Approval for this work.

Many thanks and look forward to hearing from you.

Regards,
Venetia

Venetia Brown
University Teaching Fellow and
Director of Programmes
Post-qualifying Nursing and Child Health School of Health and Social
Sciences Archway Campus Highgate Hill London. N19 5LW

mailto: v.brown@mdx.ac.uk
Office: 020 8411 6732

Information about Continuing Professional Development modules is available
at http://www.mdx.ac.uk/courses/CPD_WBL/health-and-social-care/courses/index.aspx

Appendix 6: Student experience questionnaire scope

The Nursing, Midwifery and Health Continuing Professional Development (CPD) Student Experience Questionnaire.

The University has identified a number of areas of University life, which contribute to, or impact on the student experience. Broadly speaking these are:

- **Engagement:** student engagement this might include sharing your experiences, giving feedback, participating in surveys and Boards of Study, feeling as though you belong, feeling like a University student, wanting to engage.
- **Communications:** to and from the University at all levels.
- **Learning and teaching:** including quality of teaching, issues around assessment, issues around achievement (results), impact of teaching, academic staff support.
- **Support for learning:** this might include the work of the Learner Development Unit for example, the Student Office services, Data and Assessment services, induction, enrolment, academic staff support.
- **Learning resources:** library, information technology, e-learning.
- **The learning environment:** classrooms, study areas etc.
- **Support services (non-academic):** counselling, welfare, money, finance, catering, student concessions, accommodation, childcare, disability support.
- **Student life:** Middlesex University Students Union involvement, social and extracurricular student activities and societies, bars and entertainment.
- **Sport:** competitive sport, exercise classes, gym membership.
- **Careers service:** careers advice, personal development planning, employability skills.

Appendix 7: Student experience questionnaire

The Nursing, Midwifery and Health Continuing Professional Development (CPD) Student Experience Questionnaire.

ABSTRACT

Since 2007 the University has been focusing on improving the student experience for all students whether full time, part time, undergraduate, post- graduate or work-based. This questionnaire aims to obtain your views as nursing, midwifery and health students on study days, standalone modules, or longer programmes such as a BSc or MSc.

The Nursing, Midwifery and Health Continuing Professional Development (CPD) Student Experience Questionnaire.

The University has identified a number of areas of University life, which contribute to, or impact on the student experience. Broadly speaking these are:

- **Engagement:** student engagement this might include sharing your experiences, giving feedback, participating in surveys and Boards of Study, feeling as though you belong, feeling like a University student, wanting to engage.
- **Communications:** to and from the University at all levels.
- **Learning and teaching:** including quality of teaching, issues around assessment, issues around achievement (results), impact of teaching, academic staff support.
- **Support for learning:** this might include the work of the Learner Development Unit for example, the Student Office services, Data and Assessment services, induction, enrolment, academic staff support.
- **Learning resources:** library, information technology, e-learning.
- **The learning environment:** classrooms, study areas etc.
- **Support services (non-academic):** counselling, welfare, money, finance, catering, student concessions, accommodation, childcare, disability support.
- **Student life:** Middlesex University Students Union involvement, social and extracurricular student activities and societies, bars and entertainment.
- **Sport:** competitive sport, exercise classes, gym membership.
- **Careers service:** careers advice, personal development planning, employability skills.

Questions about your experience as a student on a healthcare CPD module/programme

Q1.

Taking into account the 10 elements of the student experience described above, please rank these in order of importance where 10 is the most important or relevant to you as a health care CPD student and 1 is the least important or relevant.

Elements of the student experience	Rank from 1-10
Engagement	
Communications	
Learning and teaching	
Learning resources	
Support for learning	
The learning environment	
Support services (non-academic)	
Student life	
Sport	
Careers service	

Q2.

Of the 10 elements above, which would you say the University does well? List all that apply and where possible give an example from your own experience.

Q3.

Of the 10 elements above, which would you say the University *does not* do well? List all that apply and where possible give an example from your own experience.

Q4.

Do you think that the University recognises the specific experience/needs of the healthcare CPD student? Tick one statement.

Strongly agree	Agree	Disagree	Strongly disagree

If you answered *strongly agree/agree* please go to Q5.

If you answered *strongly disagree/disagree*, please go to Q6.

Q5.

If you answered *strongly agree/agree* to Q4, please explain in what ways.

Now please go to Q7.

Q6.

If you answered *strongly disagree/disagree* to Q4, please explain in what ways.

Q7.

What in your view would improve the student experience for you as a healthcare CPD student at Middlesex University?

Q8.

Do you feel like a University student?	Yes	No

If not, why not and does it matter? Please comment below:

--

If you answered yes to Q8, what was it that made you feel like a University student? Please comment below:

Finally some questions about you...

Q1.

Please list the modules/programmes you have undertaken since you qualified.

Q2.

What module/programme are you taking now?

--

Q3.

Who is funding your current study?	
Employer	Self-Funding

Q4.

How old are you?				
20–29	30–39	40–49	50–59	60+

Q5.

How long have you been qualified?				
0–5 years	6–10 years	11–15 years	16–20 years	21+ years

Thank you for taking the time to complete this questionnaire. It will be used to identify ways in which the healthcare CPD student experience can be improved.

Hi V,

I have read through this and have just a couple of comments. Firstly it is Learner Development Unit—might as well be precise! Secondly for Q1 I would list in the 10 elements in box format with a box for the number and I would add into Q2 and Q3 something like list all that apply as sometimes students might when they read that only list one thing. The rest looks okay to me.

Hi Venetia—looks good, a few comments:

- Question 2, what about asking for an example so you get more specificity
- Question 3, likewise an example would give you much richer data
- Question 4, I would recommend you use a four-point agree/disagree scale—much more robust in terms of validity
- I would keep the funding question in—might be fertile ground for some cross-tabulation.

Regards, Kay

The Nursing, Midwifery and Health Continuing Professional Development (CPD) Student Experience Questionnaire.

ABSTRACT

Since 2007 the University has been focusing on improving the student experience for all students whether full time, part time, undergraduate, postgraduate or work-based. This questionnaire aims to obtain your views as nursing, midwifery and health students on study days, stand-alone modules, or longer programmes such as a BSc or MSc.

The Nursing, Midwifery and Health Continuing Professional Development (CPD) Student Experience Questionnaire.

The University has identified a number of areas of University life, which contribute to, or impact on the student experience. Broadly speaking these are:

- **Engagement**—student engagement this might include sharing your experiences, giving feedback, participating in surveys and Boards of Study, feeling as though you belong, feeling like a University student, wanting to engage.
- **Communications**—to and from the University at all levels.
- **Learning and teaching**—including quality of teaching, issues around assessment, issues around achievement (results), impact of teaching, academic staff support.
- **Support for learning**—this might include the work of the Learner Development Unit for example, the Student Office services, Data and Assessment services, induction, enrolment, academic staff support.
- **Learning resources**—library, information technology, e-learning.
- **The learning environment**—classrooms, study areas, etc.
- **Support services (non-academic)**—counselling, welfare, money, finance, catering, student concessions, accommodation, childcare, disability support.
- **Student life:** Middlesex University Students Union involvement, social and extracurricular student activities and societies, bars and entertainment.
- **Sport**—competitive sport, exercise classes, gym membership.
- **Careers service**—careers advice, personal development planning, employability skills.

Questions about your experience as a student on a healthcare CPD module/programme

Q1.

Taking into account the 10 elements of the student experience described above, please rank these in order of importance where 10 is the most important or relevant to you as a health care CPD student and 1 is the least important or relevant.

Elements of the student experience	Rank from 1–10
Engagement	
Communications	
Learning and teaching	
Learning resources	
Support for learning	
The learning environment	
Support services (non-academic)	
Student life	
Sport	
Careers service	

Q2.

Of the 10 elements above, which would you say the University does well? List all that apply and where possible give an example from your own experience.

Q3.

Of the 10 elements above, which would you say the University *does not* do well? List all that apply and where possible give an example from your own experience.

Q4.

Do you think that the University recognises the specific experience/needs of the healthcare CPD student? Tick one statement.			
Strongly agree	Agree	Disagree	Strongly disagree

If you answered *strongly agree/agree* please go to Q5.

If you answered *strongly disagree/disagree*, please go to Q6.

Q5.

If you answered <i>strongly agree/agree</i> to Q4, please explain in what ways.

Now please go to question 7.

Q6.

If you answered *strongly disagree/disagree* to Q4, please explain in what ways.

Q7.

What in your view would improve the student experience for you as a healthcare CPD student at Middlesex University?

Q8.

Do you feel like a University student?	Yes	No

If not, why not and does it matter? Please comment below:

If you answered yes to Q8, what was it that made you feel like a University student? Please comment below:

Finally, some questions about you...

Q1.

Please list the modules/programmes you have undertaken since you qualified.

Q2.

What module/programme are you taking now?

Q3.

Who is funding your current study?	
Employer	Self-funding

Q4.

How old are you?				
20–29	30–39	40–49	50–59	60+

Q5.

How long have you been qualified?				
0–5 years	6–10 years	11–15 years	16–20 years	21+ years

Appendix 9: Transcripts of focus groups

VB: OK, right, let's get going then. I just want to say thank you for agreeing to take part in this focus group and just to remind you that we'll be, err, conducting the group for about a maximum of half an hour or so, but what I'm interested in as I said is that I'm, err, I'm engaged in a, err, project on the student, the CPD student experience and what it is like for you as students at, err, Middlesex University taking part in, errm, Continuing Professional Development, err, modules or longer courses. As I said before, erm, I filled out a, I issued, administered a questionnaire to CPD students about a year ago and the results that I got from that were really quite interesting and what I want to do is explore some of those issues in more depth with a group of people who are doing CPD.

1.02

VB: So can we just start off really by, I just want to start off by asking 'What the student experience is like for you as, you know, a student at Middlesex doing the courses that you've done?', you've all done courses here before doing the BSc haven't you? So you've all done single modules and now are on a longer programme. What's it, what has it been like for you, what's been good, what's been not so good? What would you change? What does the University to do well? Not so well? Anybody? And remember as I say this is all confidential.

1.42

P1: For me, errm, I don't feel like a student because I'm just here once a week.

VB: right

P1: I don't, whereas before I graduated I was here every day and, you know, was in a lot of the time at the library so I actually felt part of, you know, the student of Middlesex, whereas now I just come for the CPD once a week or every other week as some modules are and go home so.

2.04

VB: so do you, do you not, so you don't feel like a University student and that's different to how it was as a pre-reg student?

P1: yep, yep

General agreement

VB: is that right?

P2: yeah I agree with her. You don't, you just feel like you come in, have your lecture, and go home.

VB: Right. So as a pre-reg student. Sorry carry on Amanda

P2: you don't feel part of the University when you just come in once a month or you're just coming in for that module, for that couple of hours and then you go home. But I don't feel like a student like I did when I was training.

2.38

VB: right. Tell me more about that, and what is it because of the way that you access the University? Or your attendance? Or is it

P2: yeah, I think the attendance because we're just sort of coming, just like,

P3— I think it's maybe the way the whole study has been structured. We come in once, let's say this one is once a month, previous ones have done maybe once a week or once in two weeks. We do come in. Soon after the lectures everyone packs their bags off they go. So you don't really meet other students because I've been to Hendon, I've seen the students in groups discussing whatever needs to be discussed as a group which I think they do come out with something whilst you sit there as a lone student trying to get something out of what you've been taught or trying to follow a structure. For instance I was at the University Hendon yesterday from night shift to see, to find out some books which were in cataloguing so I was told to wait for the librarian 'til about 11 o'clock and I was from work the whole night. So I decided to ask for some dissertation work to go through which was quite interesting and I have to stop in between and go to the librarian and by then and the books were being shelved so I had to go back and look for the book but sitting there I saw the other students in groups, you know, doing their discussions, interesting and laughing and I was thinking look at me sitting here with no one to discuss my anything with, trying to get something out of the whole thing and it was so depressing!

4.18

VB: oh dear!

P3: I was really depressed! I got home about 2 o'clock, yes I got back after, I thought I'd give it hours to go through the dissertation so I have to sit down and make sure I follow the structure and everything, come home and went to bed about 2, it was... you don't really feel like, I would say, a proper student. Being a CPD student is quite different from being those students on the long. It was really, yeah

VB: So tell me what you think... Sorry carry on...

P4 I just think the reason for that is though, is that everyone is working, they have got jobs and other commitments. When you're a, when you're a full-time student that is your, that is what you are doing. They're a full-time student so they have got time to sit and chat with their ermmm, like we talk to our colleagues at work and stuff. So in a way they have more time, they're on less of a, I think we're all rushing in here to do this, maybe come from work. I've been at work this morning and you come here for the afternoon. You know, we haven't got, been given much study time towards it. Sometimes some people are self-funders as well, so it's quite different to being a pre-reg student in that respect because that is just what you're doing isn't it, you're being a student and doing your placements.

5.29

P3 I agree with you because sometimes when I come here as soon as the lesson is finished then I have to rush off to pick up my son (P4: same here) as that it is why it is Continuing *Professional* Development it's not like when you are going to school, as you say, then it's a school and you're just thinking of school. Yes, we're not able to participate in a number of other things, like when we got the information pack they tell you about all the things that is happening there, even the feedback sheet that we filled out to say how did you do this, how was orientation, what happened there. I think most of these questions are not able to answer because I am not involved in it. I'm not in this part of the University like when new students are coming in full-time to university. It is different and it is just going to be different. But then the modules that you do, some modules do you need to meet up in groups and have discussions? Some...

6.20

VB: do you mean modules that you're doing as part of your CPD or are you talking about modules that you did as part of your pre-reg?

P3: pre-reg

VB: right. And where there any modules that you did as part of your CPD where you had to meet up as groups?

General yes from group

P3: Yeah I did

Mentorship

6.40

VB: and did you do that in class time?

P4: Yes I think everything I've done has been done in class time really.

P2: No we didn't. I mean, we just come in, because ours lessons were morning, so what we did, we either stayed after or we come in earlier before the class started.

VB As was that, was that, it's an interesting thing that I'm now, I hadn't really thought about this, but in terms of the way in which teaching, the teaching and learning experience is organised, is group work outside of the class time more difficult for you guys?

P2: yeah because everybody is working different shifts and it's hard, people come from a long way and sometimes it's really hard to all arrange to meet as a group,

P5: and childcare, childcare's a big one

VB: OK, OK, you've raised some really important issues already. You talked about the job and other commitments, you talked about study time, and you talked about running off to pick up the kids, all of which seem to be significant for you.

General agreement

P4: I know what you mean because it does make it more of a lonely experience because you try to get on and do it, but then you feel a bit more stressed, a bit more under pressure because there is less sharing, of like, which makes it quite hard.

7.57

VB: a lonely experience?

P4: Slightly,

P2: you're on your own at home, when you're, like for the dissertation it's quite hard when you're on your own at home and you're looking at it and you're like, ummph, you've got sort of no one that you can, sort of, like if you're in class or if you, like know people in your class you could sort of ring them up and discuss it or arrange to meet so you've got someone to fall back on. I mean you can ask your colleagues at work and that but when you're actually doing it yourself, they'll help

you but they're busy themselves. But you know like if you're actually, could sit with someone that's doing it as well in your spare time, it's, I think it helps more.

8.32

VB: so it's, so they, and, Stephanie

P1: you know I agree with what she said. I went to Hendon myself and I was lost, I didn't even know where Hendon was. When I got there in the library nobody there to help you. I went upstairs, it's about, I don't know how many floors they have there, I don't know where to go, you know here you can access. Nobody even asked you, like it's my time here where do I go, I don't know where to get the dissertation. I was just lost. I didn't like the experience as well, it did feel quite lonely, yeah.

VB: yeah. Right, so it was the lonely experience being a CPD student at Hendon because it was huge

P1: Yep

VB: the concept of being the lonely student I think is quite interesting. Has that been your experience for every module that you have done as part of your CPD, do you think? Or do you think it's about the dissertation

No, no,

P3: all of them, yes all of them

VB: is that about, erm, you know when as a pre-reg student you're part of, say, September '09, or whatever,

Yeah

Yeah, you have an identity

VB: tell me about that

P4: well you have an identity don't you, you become part of that cohort, that group of people and then you also, in my training, because it was in '91, you were part of the hospital as well, although we did the Diploma as part of project 2000, we were part, we trained at King's, we felt an identity at the hospital, so you sort of had, that was very different.

10.08

VB: Ok, so, the, in out-ness of CPD, erm, is that convenient as well?

P2: Yeah

VB: OK

P2: it is when you're working

General agreement

P2: but also when you're coming in to Uni just for lectures and then you've got your independent study time, I find sometimes it's hard at home to study as well. You know, like to focus yourself, to make yourself study.

VB: is that different from pre-reg?

P4: I don't know, it was always quite hard!

Agreement, laughter.

P2: I know, I just find it harder to try and get focussed know.

Agreements

P2: When you're working full-time as well, so that's why

10.50

P1: It's different from pre-reg because when you are there you are there full-time student, so don't have to think 'oh I have to work tomorrow so I have to get through this load of work'. And again combined with your housework and then you say 'oh tomorrow I have to go to work so have only this many hours to finish this so you know, you always have to set yourself time and give yourself deadline to get through it otherwise it's impossible.

11.15

VB: OK, so the nature of studying and producing work as a CPD student, that's, you're, you're approach to it is different. Is that what you're saying?

Yeah

VB: or have I got that wrong? Or is it just that your situation is different?

P3: I think it's the situation

VB: right, and, so tell me a little bit more about the differences, what's different now? A. You're working.

P1: For me, I didn't have kids so now I have children which you just have to work around them, maybe when they sleep you study. You cannot just

11.56

P3: Sometime when you plan it just don't happen how you plan it

VB: so the plan doesn't always turn out the way you want it to because...

P3: Of other commitments, you know, I have a 4 year old son and I might go home to today and I'm not working tomorrow and I'm thinking tomorrow's the day to do, and then something may happen, maybe he's ill, if he's not gone to nursery, as soon as he's gone to nursery I need to do some and then look it's three and it's time to pick him up from nursery. I didn't even get to do what I wanted to do and planned so it's more family commitment as well.

VB: right, right, and then you go, your back on shift

P3: I have to think, OK Thursday is finished, Friday I'm back at work.

12.34

VB: right

P3: And I've not done what I wanted to do

VB: OK and what about when it comes to assignments, you know, planning for assignments, you've talked about studying, ermm, one of the things that was mentioned in the survey was the fact that you have limited time to actually, erm, concentrate on your studies because you are working and because you're, so that you've put aside this day, that is exactly what you have described, and if something happens on that day the time is lost. Is that?

Agreement

P4: Would there be anything in having some protected time as part of the dissertation as the four afternoons but saying making it four days but the students get a couple of mornings that their employers kind of have to give them so they get the opportunity to do some study?

VB: so you make the dissertation all day, four full days, where the morning is teaching and the afternoon is self-directed? But it's timetabled so that your employers are obliged to

Yeah

P4: I don't know whether even those two days would help

P1: It's different for us because we're doing it in our own time so, but I myself, let's say if I'm coming here for a lecture I would say 'OK if I'm early when I finish I'll have my lunch and probably this afternoon I have to sit here and do the work in order, you know, for me to catch up with what happened that classroom and continue with what I want to do because for me there is no time given from work so it's all in my own time

VB: no time at all

P1: So it's all in my own time

VB: right, does that, is that the, how does that feel for other people, is it, are you, how, are you all doing this in your own time? Or

P3: No we have 50%

P5: This one I have, all of the other ones I did

I did everything in my time as well

VB: so would you say mostly it's in your own time?

Agreement

P4: This one I've been given the time to do

VB: right, OK, OK. So that's, and did you, have you been paying for this yourself

P3: Yes, self-funded, my whole CPD

P4: All the other modules I've done as well except for £300 which my new employers

P3: Oh, I don't know how much I've paid for CPD, almost 240 credits. I've been self-funding

VB: and, but you've, the Trusts, some of the Trusts have actually paid for you, but I'm hearing there is a combination of self-funding, seconded, some Trusts give you some study time but other Trusts make you study in your own time. OK, so, that's a real variable experience, isn't it.

P3: How, um, financially how the University does not help is they do not allow you to pay, like, in parts

Exactly

You have to pay everything in one go

VB: right, right

It's a lot of money to pay

P5: So especially now the fees went up, it's just crazy, how

P3: And they don't have, I find, personally for this semester when I had to wait for my employers to pay for my fee and until recently I went to the student office to find out what's happening cos I didn't know they didn't have the financial office downstairs again and then it was only when I went to the student office they told me that I need to ring the number in Hendon and by the time I get through to them they've blocked me and I wasn't able to access anything on the University campus and things like that. I think, I could find my results, I even had to speak to Venetia about it and then until it was sorted about a week after that I was able to access things again. But I think they should consider, I mean it's a lot of money, it's a lot of money

P5: And also you can't get books from the library when you're blocked you can't access the books.

P3: You can't do nothing

VB: No, they call it a financial hold.

P6: For me it's quite different for, because they were quite flexible with the payment.

VB: So you had a different experience?

P6: Yeah, I had a different experience, they were very flexible, I have been paying it in instalments

VB Have you?

Yes

VB: So for each module how many instalments? When you were paying for the dissertation module how many instalments were you allowed?

I got three.

VB: OK.

Yeah. Because I was paying 300 almost every month

VB: You pay monthly?

P6: Yeah, so it was quite, because I was 900

P4: Yeah I paid 600 and then had to try and get the last 300 from my employer

VB: So you had two instalments?

P4: Two instalments, yeah and they paid.

P6: Until recently I did get a letter to say they've realised that I was waiting, so I have to pay the money late and I have to e-mail them back, it was so, I was brought from, so I have to, but I've never had problem 'til

VB: So there's a variable experience, isn't there

17.34

P3: Because I'm not the only one, when I did the last, um, the last, um, module there was another girl there who said they wouldn't allow her to pay instalments as well, she had to pay everything all. I had to pay 1225 all in one go

VB: Oh my goodness

P4: I paid my 600 and I did get a letter from them saying you've got to pay the last bit and then, but I, they didn't block me

P3: They blocked me

P5: I was blocked as well

P6: They send you letters to remind you of the payments, how much is left to be paid

VB: OK, OK, so there does, so there's something there about the University experience, if you don't mind we'll go back to the teaching and learning experience in a minute, but the kind of administration, is that, if there were things you were, um, you would want to change about the University, where does fees and admin and all that stuff come in to it? Would you say that we do that well?

18.31

P6: I think the problem with

VB: You've had quite a good experience

Yes I did it was incredible

P3: I would say it is not done well there is not much information provided that if you want to speak to someone you can do that

P5: Also, like when I was sorting out the arrangements of the, for the fees to be paid, eventually when I, erm, got round to doing that, when the cheque came through, because I actually ended up going to a charity for them to pay for me, when they, they don't send an you invoice, it's so hard to get an invoice from them

P3: It's what you print off online

P5: And then the, and then the administration of the charity they don't acknowledge just something just written, they want a proper invoice, so to just, when I called them they weren't listening to me, the charity called them because it's an organisation they did so it's very frustrating, so you're just left in between, you know, they want an invoice, you can't get an invoice. It's just, yeah...

P1: Sometime when you phone the student office for the information, like when I did my contraceptive course because I deferred because I went to have a baby and then on the phone they didn't know about me because I was also in line to start in the January because I had deferred the previous year and I had to go round and round and I couldn't find any information until I got in touch with the module leader

VB: right, OK, so it sounds like information and communication is a, er, for you, was something we could do better. OK, erm, so you talked about not feeling like a University student and saying it didn't actually matter and that's because of the nature of your participation. Do you think that the University recognises your, do you think you've got a) do you think you got special needs, I don't mean that in, you know, as a part-time CPD student and if you have do you think the University does enough to recognise your, your um, CPDness, your status as CPD students as supposed to CPD students? Do you feel they take that in to account at all?

P1: Erm, I don't think with respect to library uses, and well books, because you know we are not here every week so when we get the books it becomes difficult to, so I think they should look into when we're not here, yeah, longer term loans or in a simple reason because sometimes the book is not available when we order it we are not here to pick it up you actually just have to make that extra journey either to come and return the books or just to get the book.

VB: you can obviously renew. What about then the University, the er, learning resources are moving more and more towards e-journals and e-books

P4: I think that's very good, I think that's actually, yeah, the development of the website, from having done courses here over the years, I did my contraceptive course here and gendered health and welfare course quite a long time ago and that, you can just see, that's a good progression I think. The UniHub and the fact you can get so many of the resources online, you can hand in your essay online, library stuff, I think that's good, very good

General agreement

VB: Right, so the kind of er, all that the development of our online platforms, as it were, and the facilities

P4: And it's not too difficult to use, I mean I think it's pretty good

VB: Right, has anybody had any problems with using myUniHub or online, is it worked OK for you at home?

General agreement

P5: Sometimes accessing the books, online books, sometimes you can't, you know when you're reading the first page you cannot go to the second page, I don't know why, sometimes, but on other courses I have been able to access

VB: OK, because this particular module all, I think, certainly Aviards online, Judith Bell I think might be online as well, that's how to do, doing your research project I think it's called but the fact that you can, you don't have to make a special journey in order to get the books and you don't, you know, you're not so time limited are you in terms of accessing that. So for you the online, being a CPD student is helped by the online facilities and online resources. OK that's, that's, that's really good

P1: And it's single password for everything, like before it was so complicated, but now it's easy so one password you just get anywhere, library or anything so it's just less complicated than it was before

VB: OK, now imagine that you, er, were a, you are talking to someone who's planning a nursing CPD course, specifically with your needs in mind. What would you say to them about teaching and learning, timetables, you know if you think about what you've done so far in the modules you've done. Is there anything that you think we should be taking in to account as teachers or doing more about, or including more in or whatever, as teachers teaching, offering you CPD? Is there anything that we're, would make this a better learning experience for you

P4: Yeah I think it's if you come in, as we've discussed earlier, we do the morning session teaching and then maybe the afternoon session like a group discussion where we bring our topics together and we discuss it together because as soon as we leave we don't meet 'til about 2 weeks' time or something and you've got other commitments and sometimes you go home and you just put your work away 'til you are ready to come back again, that's when you rush to go through things, so if it's a day's lecture then you can do the teaching then in the afternoon

VB: So a full day, where the morning is taught and the afternoon is more, sort of, networking, sharing,

P4: And discussion

P4: I think it's more about having the time, what I'm struggling with is the time to get the work done, so, and that you kinda do on your own really, I don't know how you get round that, I think it's just having too many commitments

VB: right, right but something, so timing we need to think about that, think when we're putting our courses together about the nature of your experience and this thing about, you know, preparation for assignments, setting aside specific times and being aware that if it doesn't happen in that time that time is, is lost and gone. That opportunity for networking, I think is erm. What about this thing about cohort effect, does that matter? You know, that fact that you haven't got that anymore.

25.27

P5: I don't know if it matters anymore because people do different modules and always be, I might be here today with them but I'll, next time I'll have a whole, I think we expect that as postgraduates by now

VB: So the expectation is that that's the way it's going to work

P5: Yeah, all I could say is that because there is a move to Hendon if, every module I think they need to be orientated to the campus because CPD students are only there for maybe one particular module so they shouldn't just say OK maybe they might have know, you know, I think there needs to be some type of orientation

VB: there are campus tours being arranged and you can also do a virtual tour online so it's worth knowing about it if you're going to be continuing your studies at, as you all will be, some of you will still be taught at the Whittington across the road for some courses but most of the provision is going to be delivered from, from Hendon. That's, that's. So one of the things, and you talked about this online resource, one of the, er, teaching and learning opportunities that we have available is what's called a discussion board, you know, you have it on UniHub, so if we can't get you to, you know, network as a group, do you think we should be using things like, would you use more to, erm, to network with other colleagues

General agreement

P6: We did with [REDACTED] use the discussion board

VB: did you use that?

P4: We did, yes we did

VB: because I have seen that, I have not a clue what I'm supposed to be doing!
Someone help me please!

P6: Everyone was bring their ideas on what had to be done and Trish always respond

VB: OK, so it was, so it was moderated and you had a particular focus did you for?

P4: We had to put things, upload things on to it as well, didn't we

VB: Right, OK, would that, would, would that help, did that help with that sense of, did you gel more as a group because of that

P6: Yeah because anytime, we do go on it most of the time so that by the time we come back to class we really have an idea of what we've discussed already or what we are about to discuss and everybody is putting in some input, so it really did

P4: I think the difference with that module as well is cos we were all learning about the same thing, weren't we, whereas guess here we're all dissertations about different things it is different isn't it? We've had less problems

VB: So, and what about if your contributions on the discussion board were part of the assessment

P4: Yeah, then maybe we'd have to use it, I think that was Trish's thing that we had to go on the discussion board – why we were on there!

VB: You could do it any time you wanted?

P6: Yeah, anytime, not restricted

P4: I think it was part of our assessment

P6: It was, so any topic we do we have to go to the discussion board and write something about what we have done or we are just about to do

P4: I think it was formative assessment, it wasn't compulsory

VB: Cos I'm just thinking we could've used the discussion board for your research questions, you could've uploaded them and got people to ideas

General agreement

VB: there was something else I was going to ask you about admission, OK yeah, the other thing you talked about was the, you know, the journey of the CPD student being in, out, in, out, and convenient, choosing modules that, what if you did a degree where instead of it being things that you put together yourself there was a degree where you had to do x many modules, do you see what I mean, so, you know, the core, they are all core modules, everybody has to do it, it wasn't about using your pre-accreditation in your degree, um, because then you would have a cohort, you'd all be studying the same modules at the same time. Compare and contrast that with the BSc Nursing Studies where you do a bit, you know, and then you come together and you have

29.47

P5: I think the way it's done now is better, then you can bring in whatever you're bringing in and, I think it's more flexible now whereas the other one would be very restrictive

VB: Right so you need the flex, you're prepared to almost offset the cohort thing, with the flexibility, cos is that more important to you than

P4: I think it's more important to be able to bring, to have the pre-accreditation for some of the stuff that you've done in the past, I think that's, that's good

VB: Right, OK, OK, so there is something about a trade-off, by the sounds of it. You know, the benefits of full-time participation and the benefits of having group support, the trade-off is when you lose that but you get a bit more flexibility which you need because you're in full-time work

P5: Yeah and then you get to choose your own course. Yeah because I'm sure everybody has a different path of

VB: Yeah, so a fixed path wouldn't be

P5: it would be very restricting, yeah

VB: OK that's been so useful, erm, just tell me what for you then would be the single best thing we could do as a University to help you as a CPD student? What would have the most impact do you think, the most immediate impact on your experience as a student? Or is, or you know, not. Or indeed, what would, because don't forget your employers contribute to your students experience as well in some ways, what is it that either us as a University or your employers could do to make your learning experience more positive?

P5: Time, being allocated to study. Funding, if possible

VB: Right, so not having to pay for it yourself

General agreement

VB: Not having to do it in your own time, be given study time, and not having to do it in your days off

P4: Obviously there is some much of it you're going to have to do some of it, you know, quite a lot of it in your own time, but it would be nice to have a bit

P5: At least half of it

VB: Or some negotiation, do you think your employers recognise what you're doing in your own time

P6: Not everything

VB: They don't recognise what it means to be, so when you're being paid for, does somebody come back and say how you're doing?

General agreement of No

P4: I'm quite appreciative now I've had a bit of help towards it so I think, and time towards it, so I think that actually I feel a bit happy about it whereas in the last module I paid for myself and I think I did it in my own time so

32.32

VB: So that's an interesting thing that I hadn't picked up before but it's about employer engagement with your progress, would you say that they are?

General: No they are not interested

VB: They're not interested?

P6: My employer knows I am studying but they don't really want to know, yes, because of the financial aspect of it

VB: So they want to know, but they don't want to know

P6: They don't want to know about the financial aspect of it

VB: They're not interested in what it's cost you

P6: Not at all, they don't want to know but they know you are studying towards something, but because they really go in to it they have to help you with it, finance, so they just know you are studying in your own time and you are self-funding so they don't want to know

VB: And do you, somebody said that they weren't interested

P2: My Trust is funding me but no one ever asks me, would I need some help or any guidance, no one even mentions it

Agreement

VB: Because my thought was, that particularly for Trusts who are funding, that you'd be, they'd be interested in

P2: They've funded all mine and no one has ever come and said to me, how did you get on with this one?

VB: Doesn't that not bother you?

General laughter and agreement

P2: No one's ever asked me anything

VB: Does anybody ask anybody?

General No

P4: I've been asked how I'm getting on, what topic I'm doing, you know, would I like to do a presentation about it once I've finished, you know, but obviously they expect something back which is fair enough, but I think with all CPD erm, you know, they are more interested, obviously, in things that are going to enhance your practice and make you be able to see more patients. I'm learning to fit implants at the moment and they are much more interested in how that training is going because that will mean I will be able to see more patients and see more of those patients and that will impact on the service more so

VB: OK, so your degree and having a degree will be a huge achievement, obviously, for you girls, but the employers

Yes, yes

P6: But not to the employers

P2: It's not going to make any difference to your job

VB: It's not going to make any difference to your job at all?

P4: I think it might, I think it might. It will, in the long term

VB: Do you see it as a way of giving you career progression? Do you think having a degree will help you in your employment?

Agreement: Yes

VB: So it's like a passport out, if you want,

Exactly

Yes

For me it's a passport out

VB: OK, that's kind of quite interesting, I kind of thought that employees, employers, were more engaged, I thought you had to report back

P4: I think some are actually, I've been asked to quite a few times

VB: In your experience

P6: In my experience if it's a single module that's to help with your practice they are more interested

P2: Like mentorship, they're like, when are you finishing that because they want to make you a mentor, but other than that they're like

P6: Yeah, mentorship they will fund it because they have students coming in and you have to mentor them, they are happy, they will fund that one for you, but not with

P5: Regarding to mentorship, now they're not going to fund any more mentors

Really? Really?

P5: Because there are more than enough mentors out in the workplace so they think that anything that has to be done has to be done individually, there will be nothing else coming up

VB: You've got enough

P1: But mentorship is one of the mandatory training in our Trust now, isn't it. I wasn't funded for it even when I finished mentorship I am actually the one who went to my manager and said could you give me a student I am now a, you know like,

P5: I'm in a different situation, I'm a Band 6 but I haven't done mentorship, so they still keep giving me students, and sometime they give you like student and second mentor and first mentor and both person hasn't done the mentorship course so I always have to go back and remind do you see what you've done because it shouldn't be this way, you shouldn't have to change it round and they keep doing it on many occasions

P2- At Chase Farm you can't become a Band 6 until you've got your mentorship, because that's part of it

VB: Ok, so what's

P6: You're right in, because I've attended an interview which having a mentorship course requirement to get the position and the person who got the position was not, um, doing their degree, had done their degree, had not done their mentorship and they got it and the feedback I got from the interviews was 'there's nothing I can tell you to improve, but we had to do, like, eeny meeny miney mo, 'cos everyone was similar'. I said OK, however I didn't get the position and the second thing is I had to say I am not going to mentor another student until I am sent to do the course and it is how I was sent to do the course and my manager did ask me whether or not I did pass or whether or not you finished, or whatever

VB: Do you mind them not asking, do you mind them not being interested?

P2: I mean they should ask to see your certificate to actually prove that you've done it 'cos you could say 'well I've passed the mentorship' and really you haven't because they wouldn't know 'cos they never ask to see your certificate do they?

P5: 'Cos when I went back, you know, to my clinical educational office leader for Royal Free they didn't actually have the updates for what I've done in the past so their record was quite older than what I have already done, so I actually had to go and tell them what they had to feedback with the University and liaise and find out what I had done and where I stood so

VB: What about your PDPs and your appraisals? Do they not ask about what you've done in those, those meetings?

Agreement: yes they do

It's a new folder and everything new, it's something they have to do.

P2: They do ask you what you want to do and where you want to progress to. But I had an appraisal last October time, November time, but because it's so busy on our ward and they bought a Band 7 from, um, A&E at Barnet to do our appraisals, now this guy they brought in didn't even know us. So I said to him 'how can you do an appraisal on someone you don't even know' and he went 'oh I'm just going to ask you what your plans for the future are', I said 'but you're not giving me any feedback on my practice or anything' and he went 'oh you can ask your Band 6 that' and I was like, I even said to my matron 'what was the point of that, he doesn't even know me' and there were a few of us who had this Band 7 from Barnet do our appraisals but I didn't feel like it was a proper appraisal, but our matron, I don't know, she just don't seem interested

VB: That's a real shame

P2: And it's just

VB: So your CPD is for you

General agreement

P4: I want to be a bit more positive about where I work as I think they are very encouraging and they are quite nice and people are interested so,

Where do you work?

P4: At the Archway centre. And I think that generally the Band 7's and the bands, and you know, the more senior management are interested, they know you're doing a degree, their interested in what you're doing and offering help, so I want to be a bit more positive! They're nice, they're positive

P5: Even the situation was for us was good when we were just the gynae ward because then everybody would get time, you would know what you would be doing next because your names would be up for it but now we've moved with the plastic ward and then you have the girls who are already there and then us, but, a single person manages the whole ward and the funding hasn't increased as of what it was before so you again struggle with the amount of staff you have there and you have to wait for your turn so obviously it's going to take more time and the manager, she's a plastic, you know, with a plastic background, she doesn't know, you know, what we should do, what we shouldn't and where we stand, so it's just, you know

VB: So it's mergers and change

P5: It just makes things difficult

VB: It's quite similar to your experience

P2: The funding I've got from Chase Farm I've asked for it and they give it to me and my colleagues as well, they've asked for courses to do and their funded as well

VB: They're kind of supportive

P2: They're supportive in your learning, but they don't ask you, they don't even ask for any feedback or come and see you, not that I think they should come and see you especially but you know it would be nice for them to say how did you get on with this course

Did you pass the course

P2: Oh yeah

Cos you're paying something

P2: Oh god yeah, yeah but they don't even come, they're paying for it but they don't even come and find out

VB: All right, that's been absolutely brilliant, thank you so much. What I'm going to do now is to, erm, get down on bended knee and ask someone if they will transcribe that for me so I've then got the paper copy. When I've got that, what I then do is to look and see what themes are coming out of it. So I'm, you know, you're feeling sorry for yourself because you're having to do all this research but I'm doing exactly the same thing as you are, identifying themes, seeing what the main issues are, and then having to do right, so what, and I've then got to write something about what you're feedback, erm, the results of the focus group, what that means for CPD students and what we can do about it makes some recommendations for practice, some of which may be accepted, some of which may not be. So that's where I'm going with that, so hopefully I'll keep in touch with you and let you know how it's going on. So that's brilliant, thank you so much.